State of Iowa

Iowa Administrative Code Supplement

Biweekly
July 5, 2017

STEPHANIE A. HOFF
ADMINISTRATIVE CODE EDITOR

Published by the
STATE OF IOWA
UNDER AUTHORITY OF IOWA CODE SECTION 17A.6

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.

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

Administrative Services Department[11]

Replace Chapter 100

Economic Development Authority[261]

Replace Analysis
Replace Chapter 106

Education Department[281]

Replace Analysis
Replace Chapter 17
Remove Reserved Chapters 85 to 93 and Chapter 94
Insert Reserved Chapters 85 to 94

Educational Examiners Board[282]

Replace Analysis
Replace Chapter 1
Replace Chapters 11 to 13
Replace Chapter 18
Replace Chapter 20
Replace Chapter 22
Replace Chapter 24

Human Services Department[441]

Replace Analysis
Replace Chapter 75
Replace Chapters 77 to 80
Replace Chapter 83
Replace Chapter 108
Replace Chapters 112 to 114
Replace Chapters 116 and 17
Replace Chapter 142
Replace Chapter 156
Replace Chapter 202

Inspections and Appeals Department[481]

Replace Analysis
Replace Chapters 30 and 31
Replace Chapter 34
Replace Chapter 102 with Reserved Chapter 102

Replace Chapter 107 with Reserved Chapter 107

Public Health Department[641]

Replace Analysis
Replace Chapter 154

Transportation Department[761]

Replace Analysis
Replace Chapter 511
Remove Reserved Chapter 512, Chapter 513 and Reserved Chapters 514 to 519
Insert Reserved Chapters 512 to 519
Replace Chapters 920 and 921
Replace Chapter 924

TITLE V
GENERAL SERVICES

CHAPTER 100
CAPITOL COMPLEX OPERATIONS

[Prior to 9/17/03, see 401—Chapter 3]

11—100.1(8A) Definitions. The definitions contained in Iowa Code sections 8A.101 and 8A.301 shall be applicable to such terms when used in this chapter. In addition, the following definitions apply:

"Assignment of office space" means space allocated by the department to a state agency for its use.

"Capitol complex" means an area within the city of Des Moines in which the Iowa state capitol building is located. This area includes the state capitol building and all real property and appurtenances thereto owned by the state of Iowa within an area bounded on the north by Interstate Highway 235, on the east by East 14th Street, on the south by the northernmost railroad tracks south of Court Avenue and on the west by East 6th Street.

"Control of assigned office space" means the ability of an agency to modify its use of assigned space without consultation with the department as long as changes do not include relocating wiring, replacing, adding or deleting modular office components, or making other modifications that would affect the floor plan.

"Dangerous weapon" means any instrument or device designed primarily for use in inflicting death or injury upon a human being or animal, and which is capable of inflicting death upon a human being when used in the manner for which it was designed. Additionally, any instrument or device of any sort whatsoever which is actually used in such a manner as to indicate that the person possessing the instrument or device intends to inflict death or serious injury upon the other, and which, when so used, is capable of inflicting death upon a human being, is a dangerous weapon. Dangerous weapons include, but are not limited to, any offensive weapon as defined in Iowa Code section 724.1, pistol, revolver, or other firearm, dagger, razor, stiletto, switchblade knife, or knife having a blade exceeding five inches in length. Pistols and revolvers are exempted from the definition of "dangerous weapons" only as set forth in subrule 100.2(2).

"Facilities" means the capitol complex buildings, grounds, and all related property.

"Memorandum of understanding" or *"MOU"* means a written agreement that specifies terms, conditions and any related costs.

"Modular office components" means parts of a modular office system.

"Modular office systems" means standard cubicle furniture; generally, two-foot, three-foot and four-foot sections that have attached work surfaces and file storage space. Modular office systems are available in new, remanufactured and recycled condition.

"Nonstandard modular office systems" means office systems that do not meet standards set by the department of administrative services.

"Office furniture" means any furnishing that is free standing and does not require installation with component parts. Examples are desks, chairs, file cabinets, tables, lounge seating, and computer desks.

"Public" means a person on the capitol complex who is not employed by the state of Iowa.

"Recycled modular office components" means used components that have been cleaned and have had broken parts replaced, but have not been disassembled and rebuilt.

"Remanufactured modular office components" means used components that have been disassembled, repainted or reupholstered, rebuilt, and have had broken parts replaced. Remanufactured components are intended to be like new.

"Seat of government" means office space at the capitol, other state buildings and elsewhere in the city of Des Moines for executive branch agencies, except those areas exempted by law.

"Waiver" means a waiver or variance as defined in 11—Chapter 9, Iowa Administrative Code.

[**ARC 3179C**, IAB 7/5/17, effective 7/1/17]

11—100.2(8A) Security.

100.2(1) *Dangerous weapons.* No member of the public shall carry a dangerous weapon in state buildings on the capitol complex except as otherwise provided in subrule 100.2(2). This provision

applies to any member of the public whether or not the individual possesses a valid Iowa permit to carry weapons. This provision does not apply to:

a. A peace officer as defined in Iowa Code section 801.4 or a member of the armed forces of the United States or of the national guard, when the person's duties or lawful activities require or permit possession of a dangerous weapon.

b. A person possessing a valid Iowa professional permit to carry a weapon whose duties require that person to carry a dangerous weapon.

c. A person who possesses a dangerous weapon for any purpose authorized by a state agency to further the statutory or regulatory responsibilities of that agency. An authorization issued pursuant to this paragraph shall not become effective until it has been issued in writing to the person or persons to whom it applies and until copies of the authorization have been received by the director and by the commissioner of public safety.

d. Members of recognized military veterans organizations performing honor guard service as provided in Iowa Code section 35A.12.

Violation of this subrule is a simple misdemeanor, pursuant to Iowa Code section 8A.322, and may result in the denial of access to a state building, filing of criminal charges or expulsion from the grounds of the capitol complex, or any combination thereof, of any individual who knowingly violates the subrule. In addition, any weapon found in possession of a member of the public in violation of this subrule may be confiscated. Charges may be filed under any other criminal statute if appropriate. Officers employed by or under the supervision of the department of public safety shall have the authority to enforce this subrule. Peace officers employed by other agencies shall have the authority to enforce this subrule at the request of the commissioner of public safety or in response to a request for assistance from an officer employed by the department of public safety.

100.2(2) *Pistols and revolvers.* No person, other than a peace officer, may openly carry a pistol or revolver in the capitol building and on the grounds surrounding the capitol building including state parking lots and parking garages. This provision does not preclude the lawful carrying, transportation, or possession of a pistol or revolver in the capitol building and on the grounds surrounding the capitol building including the state parking lots and parking garages by a person who displays to capitol security personnel a valid permit to carry weapons upon request.

Violation of this subrule is a simple misdemeanor, pursuant to Iowa Code section 8A.322, and may result in the denial of access to a state building, filing of criminal charges or expulsion from the grounds of the capitol complex, or any combination thereof, of any individual who knowingly violates the subrule. In addition, any weapon found in possession of a member of the public in violation of this subrule may be confiscated. Charges may be filed under any other criminal statute if appropriate. Officers employed by or under the supervision of the department of public safety shall have the authority to enforce this subrule. Peace officers employed by other agencies shall have the authority to enforce this subrule at the request of the commissioner of public safety or in response to a request for assistance from an officer employed by the department of public safety.

100.2(3) *Building access and security.* The department of administrative services and the department of public safety shall take reasonable and appropriate measures to ensure the safety of persons and property on the capitol complex. These measures may include, but are not limited to, the following:

a. Requiring any member of the public entering a state building on the capitol complex to (1) provide identification upon request; (2) allow the member of the public to be scanned with metal detecting equipment; and (3) allow any parcel, package, luggage, purse, or briefcase that the person is bringing into the building to be examined with X-ray equipment or to have the contents thereof examined, or both.

b. Requiring any member of the public who is inside a state building on the capitol complex outside normal business hours, other than when the building or portion of the building is open to the public during a scheduled event, to provide identification and to state the nature of the person's business in the building. A member of the public who is in a state building on the capitol complex outside normal business hours, other than during a scheduled event, and who does not have authorization to be on the premises may be required to exit the building and be escorted from the building.

c. Limiting public access to state buildings on the capitol complex to selected entrances. Access to each building through at least one entrance accessible to persons with disabilities shall be maintained.

d. Limiting hours during which public access is allowed to state buildings on the capitol complex. Hours during which public access is allowed shall be posted at each entrance to a building through which public access is allowed.

e. Confiscating any container including, but not limited to, packages, bags, briefcases, or boxes that are left in public areas when the state building is not open to the public. Any confiscated container may be searched or destroyed, or both, or may be returned to the owner. Any container that is left unattended in a public area during hours in which the state building is open to the public may be examined.

Violation of this subrule is a simple misdemeanor, pursuant to Iowa Code section 8A.322, and may result in the denial of access to a state building, filing of criminal charges or expulsion from the grounds of the capitol complex, or any combination thereof, of the individual who knowingly violates the subrule. Charges may be filed under any other criminal statute if appropriate. Officers employed by or under the supervision of the department of public safety shall have the authority to enforce this subrule. Peace officers employed by other agencies shall have the authority to enforce this subrule at the request of the commissioner of public safety or in response to a request for assistance from an officer employed by the department of public safety.

100.2(4) *Fireworks.* No person shall use or explode consumer fireworks, display fireworks, or novelties, as those terms are defined in Iowa Code section 727.2, on the capitol complex without the director's advanced written approval.

100.2(5) *Access barriers.* The director may cause the temporary or permanent placement of barricades, ropes, signs, or other barriers to access certain parts of state buildings or grounds. Unauthorized persons beyond the barriers may be removed with the assistance of officers of the department of public safety or charged with a criminal offense if appropriate, or both.

[**ARC 3179C**, IAB 7/5/17, effective 7/1/17]

11—100.3(142B) Smoking.

100.3(1) Use of tobacco products is prohibited in all space in capitol complex buildings controlled by the executive branch including tunnels and enclosures, unless otherwise designated by appropriate signs. The department shall post signs at the entrances to capitol complex buildings to publicize this rule.

NOTE: The secretary of the senate, the clerk of the house and the court administrator are responsible for areas under their control.

100.3(2) Use of tobacco products is prohibited on the grounds of the capitol complex, except as permitted by the director in designated areas or structures designated for smoking. The department shall post signs at designated smoking areas.

100.3(3) This rule shall be enforced by peace officers of the department of public safety. Peace officers other than those employed by the department of public safety may enforce this rule at the request of the commissioner of public safety or at the request of a peace officer employed by the department of public safety.

This rule is intended to implement Iowa Code section 8A.322 and chapter 142B and Executive Order Number 68 signed November 23, 1998, by Governor Terry Branstad.

11—100.4(8A) Use and scheduling of capitol complex facilities.

100.4(1) *Scheduling conference rooms.* Conference rooms, auditoriums and common areas within the capitol complex are for use by state agencies, boards and commissions for authorized purposes only. Arrangements may be made by contacting the agency responsible for scheduling the facility. The department of administrative services is responsible for scheduling all common areas not under control of other agencies. Questions about usage shall be resolved by the director of the responsible agency. General questions about scheduling may be directed to the department's customer service center at (515)242-5120.

100.4(2) *Legislative and judicial building contacts.* The secretary of the senate, the clerk of the house and the court administrator are responsible for areas under their control. Common areas in and around the Capitol Building are under the control of the department of administrative services.

100.4(3) *Iowa Historical Building events.* Scheduling of events by the public as well as by state agencies, boards and commissions to be held in the Iowa Historical Building will be coordinated by the department of cultural affairs. Groups or individuals wishing to use the Iowa Historical Building for an event should contact the Facilities Coordinator, State Historical Society of Iowa, Iowa Historical Building, 600 East Locust Street, Des Moines, Iowa 50319.

100.4(4) *Event request.* State agencies or the general public may request use of capitol complex facilities, grounds or parking lots for public events by contacting the director and completing an application provided by the department. This shall not be interpreted as an infringement on the right of assembly and petition guaranteed by Section 20, Article I, Constitution of Iowa.

a. The director shall notify the applicant of approval or denial to use the requested areas. Notification of approval may take the form of a letter to the event sponsor(s) or a memorandum of understanding (MOU) signed by the director and the event sponsor(s). The MOU specifies the conditions under which the event will take place.

b. The director may allow events if appropriate security and supervision are provided and the director determines that granting the approval is consistent with the underlying purpose of these rules and that the public interest so demands.

c. Approval for the event may contain such terms and conditions as are consistent with the protection, health and safety of occupants of the buildings and visitors to the capitol complex as well as preservation of the buildings, facilities, and grounds. The approval may also contain limitations on equipment used and its location, and the time and area within which the event is allowed.

100.4(5) *Refusal of usage.* The director may refuse to allow use of the facilities that, in the director's judgment, would be disruptive of official state business or of the public health, safety and welfare, or is inconsistent with subrule 100.4(4). The director may consider such factors as recommendations of the department of public safety, previous experience with the requesting group or other events similar to that requested.

100.4(6) *Liability.* Any state agency or public group granted permission to use the capitol complex facilities shall be responsible for any damage occurring during the event.

a. Prior to granting approval, the director may require the requesting group to acquire liability insurance in which the "State of Iowa" is named as an additional insured to protect the state.

b. As a condition of granting approval of a request for an event at the capitol complex, the director may also require that a damage deposit or bond be posted by the group making the request. The director may require the filing of a bond payable to the director in an amount adequate to cover costs such as restoration, rehabilitation and cleanup of the area used, damages and other costs resulting from this event. In lieu of a bond, an event requester may elect to deposit cash equal to the amount of the required bond.

100.4(7) *Event cleanup.* Any state agency or public group granted permission to use the capitol complex facilities shall be responsible for a thorough cleanup after the event is concluded. All debris and animal waste shall be removed.

[1]**100.4(8)** *Alcoholic beverages at events.* Consumption of alcoholic beverages, as defined in Iowa Code chapter 123, is not permitted on the capitol complex except for special events in the Iowa Historical Building, 600 East Locust Street, with the prior written approval of the director and the director of the department of cultural affairs.

100.4(9) *Distribution of literature.* Permission to distribute literature on the capitol complex grounds or in state-owned or occupied areas of leased buildings in metropolitan Des Moines must be obtained from the director. The director may designate specific locations from which literature may be distributed in order to ensure control of litter, unobstructed access to public buildings and the conduct of public business.

100.4(10) *Private parties.* No state-owned facilities, equipment or state personnel shall be used for such events as private parties, weddings, demonstrations, and rallies without the prior written consent of the director.

100.4(11) *Access hours.* Public use of state buildings is restricted to normal office hours. Hours during which public access is allowed shall be posted at each entrance to a building through which public access is allowed.

100.4(12) *After-hours use.* After-hours use of capitol complex buildings is restricted to use by state agencies and must directly relate to the mission of the state agency sponsoring the event.

a. For all buildings except the Capitol Building and the Iowa Historical Building, normal office hours are 7 a.m. to 5 p.m., Monday through Friday. Buildings are closed to the public on weekends and state-designated holidays.

b. For the Capitol Building, normal office hours are 6 a.m. to 6 p.m., Monday through Friday, except that if a legislative session lasts past 6 p.m., the closing hour is extended until one-half hour beyond the session's end. Weekend hours of public access shall be posted at public entrances. Inquiries regarding the hours the building is open may be directed to the information desk at (515)281-5591.

c. For the Iowa Historical Building, normal office hours are 8 a.m. to 4:30 p.m. every day, excluding weekends and holidays. The Iowa Historical Museum and the State Historical Library, located within the Iowa Historical Building, have different hours. Hours of public access shall be posted at public entrances. Inquiries regarding the hours the building is open may be directed to the information desk at (515)281-5111.

d. Hours listed above are subject to change. Changes in hours shall be posted on the main entrance doors to each affected building.

100.4(13) *Capitol grounds hours.* Public use of the capitol complex grounds is restricted to the hours of 6 a.m. to 11 p.m. daily. Public access hours are subject to change. Changes in hours shall be posted prominently on the capitol complex.

This rule is intended to implement 2003 Iowa Code Supplement section 8A.322.

[1] See 2004 Iowa Acts, HJR 2005 and SJR 2007.

11—100.5(8A) Solicitation.

100.5(1) Canteens, cafeterias and vending machines under the control of the department for the blind, gift shops under the control of the department of cultural affairs and concessions authorized by the director pursuant to subrule 100.4(4) are authorized methods of direct sales to employees and visitors in state-owned and occupied buildings in metropolitan Des Moines.

100.5(2) Functions involving sales to state employees or to the public in the capitol complex or in state-owned and occupied buildings in metropolitan Des Moines must receive prior approval through the event request process in subrule 100.4(4). Sales by state employees are governed by Iowa Code chapter 68B.

100.5(3) Event sponsors are responsible for contracting with vendors for sales during the event. The MOU may contain terms and conditions for vendors and shall specify the responsibility of the event sponsor to ensure that all approved vendors comply with all applicable city, state and federal laws, ordinances, rules and regulations. Vendors must have all required city, state and federal permits and licenses.

100.5(4) For the convenience of employees and visitors, the director may enter into agreements with private vendors for providing services and products within state buildings under the jurisdiction of the department. Provision of services and products shall not interfere with the business of government or negatively affect building aesthetics. The director shall solicit competitive proposals when it is probable that more than one vendor may desire to offer a similar service or product. Agreement terms and conditions shall protect the state's interest regarding liability, reasonable compensation to the state, performance and appearance standards, and other relevant concerns.

100.5(5) The director reserves the right to deny or remove any vendor who does not comply with these rules and applicable laws and regulations.

This rule is intended to implement 2003 Iowa Code Supplement section 8A.322 and Iowa Code section 303.9 and chapter 216D.

11—100.6(8A) Office space management.

100.6(1) *Purpose.* The purpose of this rule is to standardize office space management at the seat of government in order to effectively plan and utilize office space and to promote connectivity and reuse of modular office systems. The rules outline the responsibilities of state agencies relative to use of office space assigned to them by the department of administrative services and the responsibilities of the department to manage and coordinate changes to an agency's use of its assigned space.

100.6(2) *Scope and applicability.* The department's authority for office space assignment applies to all state office space, including leased office space, at the seat of government except for buildings and grounds described in Iowa Code section 216B.3, subsection 6; section 2.43, unnumbered paragraph 1; and any buildings under the custody and control of the Iowa public employees' retirement system.

100.6(3) *Office space standards.* State agencies are required to use the following standards:

a. The department of administrative services has developed and shall maintain, in cooperation with state agencies, office space standards, expressed in square feet for individual offices classified by type of work, and by occupancy, expressed as the number of occupants per building floor or major unit thereof. These standards will be used to facilitate space planning, but are not intended to be applied in an exact manner to each cubicle or office. Some flexibility may be allowed in the work plan created for managing changes to use of office space to provide for unique agency needs. All office space layouts shall comply with applicable federal and state regulations and codes.

b. The department of administrative services has defined and shall maintain, in cooperation with state agencies and Iowa Prison Industries (IPI), modular office systems standards, expressed by function and connectivity, for use by state agencies. These standards are for the purpose of facilitating reuse of modular office system components.

The requirement to follow these standards may be waived by the director when supported by a written factual and objective business case analysis that provides clear and convincing evidence to support the waiver.

100.6(4) *Notification of intended office space or office systems modifications.* To facilitate office space planning and cost-effective space utilization, an agency shall notify the department in writing at least 45 days prior to expected completion of the work whenever an agency becomes aware of possible modifications to an agency's organization, programs or mission which may require a corresponding increase or decrease in an agency's current office space requirements; or when an agency first identifies a need to modify use of assigned office space including relocating wiring, replacing, adding or deleting modular office components, or making other floor plan modifications.

100.6(5) *Work plan.* Upon written notification of intended office space or office systems modifications, the department of administrative services and the agency will negotiate and complete a work plan including but not limited to the following items:

a. A description of the intended space modification result;

b. The tasks required to achieve the intended result, such as creating construction specifications, identifying wiring needs, selection of a space planner and a moving service, and identifying related purchases;

c. The party responsible for accomplishing each task; and

d. The scheduled time line for tasks included in the design, installation (construction and move) and completion of the project.

An agency may not proceed with office space modifications in the absence of a work plan agreed to and approved in writing by the agency and the department of administrative services. The work plan shall be modified to reflect any changes in intended results, tasks, responsibilities and time schedule.

100.6(6) *Purchase of modular office components.* To obtain office furniture and modular office components, an agency may purchase standard modular office components and other furniture items from Iowa Prison Industries in accordance with Iowa Code section 904.808 without further competition.

To obtain office furniture and modular office components, an agency may purchase standard modular office components and other furniture items from a targeted small business (TSB) when the purchase will not exceed $5,000, per 2003 Iowa Code Supplement section 8A.311, without further competition.

Use of a competitive selection process is required for all purchases, unless the agency chooses to use one of the procedures above. However, competitive selection may be used for any purchase. When an agency elects to obtain standard office modular components and other furniture items through the department of administrative services' competitive procurement process, IPI and TSBs shall be part of the bidding process.

The portion of the work plan for purchasing modular office systems or office furniture shall allow for the issuance of purchase orders at least 30 days prior to the desired delivery date.

Regardless of how an agency purchases or obtains modular office components, the department of administrative services shall retain responsibility for management and coordination of office space planning.

100.6(7) *Disposal of surplus office modular components, furniture and equipment.* State agencies may dispose of unfit or unnecessary office modular components, furniture and equipment by contacting the state surplus office, as identified by the department; offering items in good repair to other agencies either through the department or directly to other agencies; or trading in used items when purchasing replacements.

Any costs associated with disposal of nonstandard modular office components are the responsibility of the state agency.

These rules are intended to implement 2003 Iowa Code Supplement sections 8A.104, 8A.321, and 8A.322 and Iowa Code section 303.9 and chapters 142B and 216D.

[Filed emergency 1/11/02—published 2/6/02, effective 1/14/02]
[Filed 4/26/02, Notice 2/6/02—published 5/15/02, effective 7/1/02][1]
[Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]
[Filed emergency 8/29/03—published 9/17/03, effective 9/2/03]
[Filed 5/5/04, Notice 3/31/04—published 5/26/04, effective 6/30/04]
[Filed 10/22/04, Notice 9/15/04—published 11/10/04, effective 12/15/04]
[Filed 10/3/07, Notice 8/29/07—published 10/24/07, effective 11/28/07]
[Filed Emergency ARC 3179C, IAB 7/5/17, effective 7/1/17]

[1] At its meeting held June 11, 2002, the Administrative Rules Review Committee imposed a 70-day delay on the effective date of rule 401—3.4(18); the delay was lifted by the Committee at its meeting held July 9, 2002, effective July 10, 2002.

ECONOMIC DEVELOPMENT AUTHORITY[261]

[Created by 1986 Iowa Acts, chapter 1245]
[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]
[Prior to 9/7/11, see Economic Development, Iowa Department of[261];
renamed Economic Development Authority by 2011 Iowa Acts, House File 590]

PART I
DEPARTMENT STRUCTURE

CHAPTER 1
ORGANIZATION

1.1(15) History and mission
1.2(15) Definitions
1.3(15) Economic development authority board
1.4(15) Authority structure
1.5(15) Information

CHAPTERS 2 and 3
Reserved

PART II
WORKFORCE DEVELOPMENT COORDINATION

CHAPTER 4
WORKFORCE DEVELOPMENT ACCOUNTABILITY SYSTEM

4.1(15) Purpose
4.2(15) Compilation of information

CHAPTER 5
IOWA INDUSTRIAL NEW JOBS TRAINING PROGRAM

5.1(15,260E) Authority
5.2(15,260E) Purpose
5.3(15,260E) Definitions
5.4(15,260E) Agreements
5.5(15,260E) Resolution on incremental property tax
5.6(15,260E) New jobs withholding credit
5.7(15,260E) Notice of intent to issue certificates
5.8(15,260E) Standby property tax levy
5.9(15,260E) Reporting
5.10(15,260E) Monitoring
5.11(15,260E) State administration
5.12(15,260E) Coordination with communities
5.13(15,76GA,SF2351) Supplemental 1½ percent withholding

CHAPTER 6
Reserved

CHAPTER 7
IOWA JOBS TRAINING PROGRAM

7.1(260F) Authority
7.2(260F) Purpose
7.3(260F) Definitions
7.4(260F) Program funding
7.5(260F) Funding for projects which include one business
7.6(260F) Funding for projects which include multiple businesses
7.7(260F) Funding for high technology apprenticeship programs
7.8(260F) Matching funds requirement

7.9(260F) Use of program funds
7.10(260F) Use of 260F earned interest
7.11(260F) Application fee
7.12(260F) Separate account
7.13(260F) Eligible business
7.14(260F) Ineligible business
7.15(260F) Eligible employee
7.16(260F) Ineligible employee
7.17(260F) Entrepreneurial training
7.18(260F) Agreement of intent
7.19(260F) Project commencement date
7.20(260F) Application process
7.21(260F) Application scoring criteria
7.22(260F) Training contract
7.23(260F) Special requirements for community college consortium projects
7.24(260F) Special requirements for community college-sponsored business network projects
7.25(260F) Special requirements for department-sponsored business network projects
7.26(260F) Special requirements for community college-sponsored high technology apprenticeship projects
7.27(260F) Special requirements for department-sponsored high technology apprenticeship projects
7.28(81GA,HF868,HF809) Special requirements for job retention program projects
7.29(81GA,HF868,HF809) Special requirements for projects funded through the grow Iowa values fund
7.30(260F) Events of default
7.31(260F) Options and procedures on default
7.32(260F) Remedies upon default
7.33(260F) Return of unused funds
7.34(260F) Open records
7.35(260F) Required forms

CHAPTER 8
WORKFORCE DEVELOPMENT FUND

8.1(15,76GA,ch1180) Purpose
8.2(15,76GA,ch1180) Definitions
8.3(15,76GA,ch1180) Workforce development fund account
8.4(15,76GA,ch1180) Workforce development fund allocation
8.5(15,76GA,ch1180) Workforce development fund reporting
8.6(15,76GA,ch1180) Training and retraining programs for targeted industries
8.7(15,76GA,ch1180) Projects under Iowa Code chapter 260F
8.8(15,76GA,chs1180,1219) Apprenticeship programs under Iowa Code section 260C.44 (including new or statewide building trades apprenticeship programs)
8.9(15,76GA,chs1180,1219) Innovative skill development activities
8.10(15,76GA,ch1180) Negotiation and award
8.11(15,76GA,ch1180) Administration
8.12(15,76GA,ch1180) Training materials and equipment
8.13(15,76GA,ch1180) Redistribution of funds

CHAPTER 9
WORKFORCE TRAINING AND ECONOMIC DEVELOPMENT FUNDS

9.1(15G,260C) Purpose
9.2(15G,260C) Definitions

9.3(15G,260C) Funds allocation
9.4(15G,260C) Community college workforce and economic development plan and progress report
9.5(15G,260C) Use of funds
9.6(15G,260C) Approval of projects
9.7(15G,260C) Community college workforce and economic development plan
9.8(15G,260C) Reporting
9.9(15G,260C) Annual progress report approval
9.10(15G,260C) Options upon default or noncompliance

CHAPTER 10
Reserved

CHAPTER 11
CERTIFIED SCHOOL TO CAREER PROGRAM

11.1(15) Purpose
11.2(15) Definitions
11.3(15) Certified program work site agreement
11.4(15) Payroll expenditure refund

CHAPTER 12
APPRENTICESHIP TRAINING PROGRAM

12.1(15,15B) Authority
12.2(15,15B) Purpose
12.3(15,15B) Definitions
12.4(15,15B) Annual appropriations—amount of assistance available—standard contract—use of funds
12.5(15,15B) Eligibility for assistance
12.6(15,15B) Determination of financial assistance grants
12.7(15,15B) Application submittal and review process
12.8(15,15B) Notice and reporting

CHAPTERS 13 to 19
Reserved

CHAPTER 20
ACCELERATED CAREER EDUCATION (ACE) PROGRAM

DIVISION I - GENERAL PROVISIONS

20.1(260G) Purpose
20.2(260G) Definitions
20.3(260G) ACE program eligibility and designation
20.4(260G) Funding allocation
20.5(260G) Eligible and ineligible business
20.6(260G) Program agreements
20.7(260G) Administration
20.8(260G) Customer tracking system
20.9(260G) Program costs recalculation

DIVISION II - CAPITAL COSTS COMPONENT

20.10 to 20.12 Reserved

DIVISION III - PROGRAM JOB CREDITS

20.13(260G) Threshold requirements—program job credits
20.14(260G) Job credits allocation
20.15(260G) Determination of job credits, notice, and certification

20.16(260G) Evaluation criteria for quality assurance—program job credits
20.17(260G) Committed funds

DIVISION IV - ACCELERATED CAREER EDUCATION GRANTS COMPONENT
20.18(260G) ACE program serving demand occupations

DIVISION V - WORKFORCE TRAINING AND ECONOMIC DEVELOPMENT PROGRAM OPERATING COSTS
20.19(81GA,HF868,HF809) Grow Iowa values fund assistance

PART III
COMMUNITY DEVELOPMENT DIVISION

CHAPTER 21
DIVISION RESPONSIBILITIES
21.1(15) Mission
21.2(15) Division responsibilities

CHAPTER 22
NUISANCE PROPERTY AND ABANDONED BUILDING REMEDIATION ASSISTANCE
22.1(15) Authority and purpose
22.2(15) Definitions
22.3(15) Program description
22.4(15) Program eligibility, application scoring, and funding decisions
22.5(15) Contract required

CHAPTER 23
IOWA COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM
23.1(15) Purpose
23.2(15) Definitions
23.3(15) Annual action plan
23.4(15) Allocation of funds and eligible applicants
23.5(15) Common requirements for funding
23.6(15) Requirements for the water and sewer and community facilities funds
23.7(15) Requirements for the economic development set-aside fund
23.8(15) Requirements for the public facilities set-aside fund
23.9(15) Requirements for the career link program
23.10(15) Requirements for the opportunities and threats fund
23.11(15) Requirements for the housing fund program
23.12 and 23.13 Reserved
23.14(15) Disaster recovery fund
23.15(15) Administration of a CDBG award
23.16(15) Requirements for the downtown revitalization fund
23.17(15) Section 108 Loan Guarantee Program

CHAPTER 24
EMERGENCY SHELTER GRANTS PROGRAM
24.1(PL100-628) Purpose
24.2(PL100-628) Definitions
24.3(PL100-628) Eligible applicants
24.4(PL100-628) Eligible activities
24.5(PL100-628) Ineligible activities
24.6(PL100-628) Application procedures
24.7(PL100-628) Application review process
24.8(PL100-628) Matching requirement
24.9(PL100-628) Grant awards

24.10(PL100-628) Restrictions placed on grantees
24.11(PL100-628) Compliance with applicable federal and state laws and regulations
24.12(PL100-628) Administration

CHAPTER 25
HOUSING FUND

25.1(15) Purpose
25.2(15) Definitions
25.3(15) Eligible applicants
25.4(15) Eligibility and forms of assistance
25.5(15) Application review
25.6(15) Minimum application requirements
25.7(15) Application review criteria
25.8(15) Allocation of funds
25.9(15) Administration of awards

CHAPTER 26
VARIANCE PROCEDURES FOR TAX INCREMENT
FINANCING (TIF) HOUSING PROJECTS

26.1(403) Goals and objectives
26.2(403) Definitions
26.3(403) Requirements for benefit to low- and moderate-income families
26.4(403) Ability to request a variance
26.5(403) Variance request procedure
26.6(403) Criteria for review

CHAPTER 27
NEIGHBORHOOD STABILIZATION PROGRAM

27.1(15) Purpose
27.2(15) Definitions
27.3(15) Program eligibility
27.4(15) Allocation of funding
27.5(15) Application procedures
27.6(15) Plan and application review process
27.7(15) Award process
27.8(15) Project management

CHAPTER 28
LOCAL HOUSING ASSISTANCE PROGRAM

28.1(15) Purpose
28.2(15) Definitions
28.3(15) Eligible applicants
28.4(15) Eligible activities and forms of assistance
28.5(15) Application procedure
28.6(15) Minimum application requirements
28.7(15) Application review criteria
28.8(15) Allocation of funds
28.9(15) Administration of awards

CHAPTER 29
HOMELESS SHELTER OPERATION GRANTS PROGRAM

29.1(15) Purpose
29.2(15) Definitions

29.3(15) Eligible applicants
29.4(15) Eligible activities
29.5(15) Ineligible activities
29.6(15) Application procedures
29.7(15) Application review process
29.8(15) Matching requirement
29.9(15) Grant awards
29.10(15) Compliance with applicable federal and state laws and regulations
29.11(15) Administration

CHAPTER 30
JOB OPPORTUNITIES FOR
PERSONS WITH DISABILITIES PROGRAM

30.1(76GA,SF2470) Purpose
30.2(76GA,SF2470) Definitions
30.3(76GA,SF2470) Eligible applicant
30.4(76GA,SF2470) Project awards
30.5(76GA,SF2470) Eligible and ineligible use of grant funds
30.6(76GA,SF2470) General guidelines for applications
30.7(76GA,SF2470) Review and award process
30.8(76GA,SF2470) Program management

CHAPTER 31
ECONOMIC DEVELOPMENT REGION INITIATIVES

31.1(15E) Purpose
31.2(15E) Types of assistance
31.3(15E) Financial assistance
31.4(15E) Definitions

DIVISION I
ECONOMIC DEVELOPMENT REGION INITIATIVE—FINANCIAL ASSISTANCE

31.5(15E) Uses of funds under the economic development region initiative
31.6(15E) Application process and approval process
31.7(15E) Reporting requirements

DIVISION II
ECONOMIC ENTERPRISE AREAS

31.8(15E) Description
31.9(15E) Funding
31.10(15E) Eligible use of funds
31.11(15E) Application process and approval process
31.12(15E) Reporting requirements

DIVISION III
BUSINESS ACCELERATORS

31.13(15E) Description and purpose
31.14(15E) Definitions
31.15(15E) Requirements and qualifications for business accelerator entities
31.16(15E) Other considerations
31.17(15E) Application procedures
31.18(15E) Reporting

CHAPTER 32
TAX CREDITS FOR ECONOMIC DEVELOPMENT REGION REVOLVING LOAN FUND

32.1(81GA,HF868,HF809) Purpose
32.2(81GA,HF868,HF809) Definitions
32.3(81GA,HF868,HF809) Allocation of funds
32.4(81GA,HF868,HF809) Credit amount
32.5(81GA,HF868,HF809) Eligible contributions
32.6(81GA,HF868,HF809) Requests for tax credits

CHAPTER 33
IOWA WINE AND BEER PROMOTION GRANT PROGRAM

33.1(15) Purpose
33.2(15) Definitions
33.3(15) Application and review processes

CHAPTER 34
WELCOME CENTER PROGRAM

34.1(72GA,HF540) Purpose
34.2 and 34.3 Reserved
34.4(72GA,HF540) Pilot projects

CHAPTER 35
REGIONAL TOURISM MARKETING GRANT PROGRAM

35.1(82GA,SF302) Purpose
35.2(82GA,SF302) Definitions
35.3(82GA,SF302) Eligible applicants
35.4(82GA,SF302) Use of funds
35.5(82GA,SF302) Application procedures and content
35.6(82GA,SF302) Application review and approval procedures
35.7(82GA,SF302) Funding of grants; contracting

CHAPTER 36
FILM, TELEVISION, AND VIDEO PROJECT PROMOTION PROGRAM

36.1(15) Purpose
36.2(15) Definitions
36.3(15) Request for registration of a film, television, or video project
36.4(15) IDED list of registered film, television, or video projects
36.5(15) Contract administration
36.6(15) Benefits available
36.7(15) Qualified expenditure tax credit
36.8(15) Qualified investment tax credit
36.9(15) Reduction of gross income due to payments received from qualified expenditures in registered projects

CHAPTER 37
CITY DEVELOPMENT BOARD

37.1(368) Expenses, annual report and rules
37.2(17A) Forms

CHAPTER 38
REGIONAL SPORTS AUTHORITY DISTRICTS

38.1(15E) Definitions
38.2(15E) Program description
38.3(15E) Program eligibility and application requirements

38.4(15E) Application scoring and certification of districts
38.5(15E) Contract administration
38.6(15E) Expenses, records, and reimbursements

CHAPTER 39
MAIN STREET IOWA PROGRAM

39.1(15) Purpose
39.2(15) Definitions
39.3(15) Program administration
39.4 and 39.5 Reserved
39.6(15) Application and selection process
39.7(15) Selection criteria
39.8 Reserved
39.9(15) Reports
39.10(15) Noncompliance
39.11(15) Forms

CHAPTER 40
IOWA JOBS MAIN STREET PROGRAM

40.1(83GA,SF2389) Authority
40.2(83GA,SF2389) Purpose
40.3(83GA,SF2389) Definitions
40.4(83GA,SF2389) Highest-priority list
40.5(83GA,SF2389) Funding
40.6(83GA,SF2389) Financial management
40.7(83GA,SF2389) Reports
40.8(83GA,SF2389) Signs
40.9(83GA,SF2389) Noncompliance
40.10(83GA,SF2389) Great places consideration

CHAPTER 41
COMMUNITY DEVELOPMENT FUND

41.1(79GA,HF718) Purpose
41.2(79GA,HF718) Program eligibility
41.3(79GA,HF718) General policies for applications
41.4(79GA,HF718) Application procedures
41.5(79GA,HF718) Application contents
41.6(79GA,HF718) Review process
41.7(79GA,HF718) Award process
41.8(79GA,HF718) Project management
41.9(79GA,HF718) Performance reviews

CHAPTER 42
IOWA TOURISM GRANT PROGRAM

42.1(15) Definitions
42.2(15) Program description
42.3(15) Program eligibility and application requirements
42.4(15) Application scoring and approval process
42.5(15) Contract administration
42.6(15) Expenses, records, and reimbursements

CHAPTER 43
Reserved

CHAPTER 44
COG ASSISTANCE

44.1(28H) Purpose
44.2(28H) Definitions
44.3(28H) Eligibility
44.4(28H) Eligible activities
44.5(28H) Application procedure
44.6(28H) Grant awards
44.7(28H) Funding
44.8(28H) Financial management standards
44.9(28H) Record keeping and retention
44.10(28H) Progress reports
44.11(28H) Noncompliance
44.12(28H) Grant closeouts
44.13(28H) Compliance with state laws and regulations

CHAPTER 45
Reserved

CHAPTER 46
ENDOW IOWA GRANTS PROGRAM

46.1(81GA,HF868) Purpose
46.2(81GA,HF868) Definitions
46.3(81GA,HF868) Program procedures
46.4(81GA,HF868) Eligible applicants
46.5(81GA,HF868) Application and review criteria
46.6(81GA,HF868) Reporting requirements

CHAPTER 47
ENDOW IOWA TAX CREDITS

47.1(15E) Purpose
47.2(15E) Definitions
47.3(15E) Authorization of tax credits to taxpayers
47.4(15E) Distribution process and review criteria
47.5(15E) Reporting requirements

CHAPTER 48
WORKFORCE HOUSING TAX INCENTIVES PROGRAM

48.1(15) Authority
48.2(15) Purpose
48.3(15) Definitions
48.4(15) Housing project requirements
48.5(15) Housing project application and agreement
48.6(15) Workforce housing tax incentives
48.7(15) Annual program funding allocation, reallocation, and management of excess demand
48.8(15) Application submittal and review process

CHAPTER 49
HISTORIC PRESERVATION AND CULTURAL AND
ENTERTAINMENT DISTRICT TAX CREDITS

49.1(303,404A) Purpose
49.2(404A) Program transition

49.3(404A) Definitions
49.4(404A) Qualified rehabilitation expenditures
49.5(404A) Historic preservation and cultural and entertainment district tax credit
49.6(404A) Management of annual aggregate tax credit award limit
49.7(404A) Application and agreement process, generally
49.8(404A) Small projects
49.9(404A) Who may apply for the tax credit
49.10(404A) Part 1 application—evaluation of significance
49.11(404A) Preapplication meeting
49.12(404A) Part 2 application—description of rehabilitation
49.13(404A) Registration application
49.14(404A) Agreement
49.15(404A) Part 3 application—request for certification of completed work and verification of qualified rehabilitation expenditures
49.16(404A) Fees
49.17(404A) Compliance
49.18(404A) Certificate issuance; claiming the tax credit
49.19(303,404A) Appeals

PART IV
BUSINESS DEVELOPMENT DIVISION

CHAPTER 50
DIVISION RESPONSIBILITIES
50.1(15) Mission
50.2(15) Division responsibilities

CHAPTER 51
SELF-EMPLOYMENT LOAN PROGRAM
51.1(15) Transition

CHAPTER 52
Reserved

CHAPTER 53
COMMUNITY ECONOMIC BETTERMENT ACCOUNT (CEBA) PROGRAM
53.1(15) Purpose and administrative procedures
53.2(15) Definitions
53.3 Reserved
53.4(15) Eligible applicants
53.5(15) Provision of assistance
53.6(15) Application for assistance
53.7(15) Selection criteria
53.8(15) Small business gap financing
53.9(15) New business opportunities and new product development components
53.10(15) Venture project components
53.11(15) Modernization project component
53.12(15) Comprehensive management assistance and entrepreneurial development
53.13 to 53.17 Reserved
53.18(15,83GA,SF344) Applicability of CEBA program after July 1, 2009

CHAPTER 54
IOWA TARGETED SMALL BUSINESS PROCUREMENT PROGRAM

54.1(73) Purpose
54.2(73) Definitions
54.3(73) Preliminary procedures
54.4(73) Identification of targeted small businesses
54.5(73) IDED administration
54.6(73) Certification
54.7(73) Request for review of certification denial
54.8(73) Certification review board
54.9(73) Decertification
54.10(73) Notice of solicitation for bids
54.11 Reserved
54.12(73) Determination of ability to perform
54.13(73) Other procurement procedures
54.14(73) Reporting requirements
54.15(73) Maintenance of records

CHAPTER 55
TARGETED SMALL BUSINESS FINANCIAL ASSISTANCE PROGRAM

55.1(15) Targeted small business financial assistance program (TSBFAP)
55.2(15) Definitions
55.3(15) Eligibility requirements
55.4(15) Loan and grant program
55.5(15) Loan guarantee program
55.6(15) Award agreement
55.7(15) Monitoring and reporting for loan, grant, and loan guarantee programs

CHAPTER 56
EMPLOYEE STOCK OWNERSHIP PLAN (ESOP) FORMATION ASSISTANCE

56.1(85GA,HF648) Purpose
56.2(85GA,HF648) Definitions
56.3(85GA,HF648) Program description
56.4(85GA,HF648) Program eligibility, application scoring, and funding decisions
56.5(85GA,HF648) Contract required

CHAPTER 57
VALUE-ADDED AGRICULTURAL PRODUCTS AND PROCESSES
FINANCIAL ASSISTANCE PROGRAM (VAAPFAP)

57.1(15E) Purpose and administrative procedures
57.2(15E) Definitions
57.3(15E) General eligibility
57.4(15E) Program components and eligibility requirements
57.5(15E) Ineligible projects
57.6(15E) Awards
57.7(15E) Application procedure
57.8(15E) Review process
57.9 Reserved
57.10(15E) Evaluation and rating criteria
57.11 to 57.15 Reserved
57.16(15E,83GA,SF344) Applicability of VAAPFAP program after July 1, 2009

CHAPTER 58
NEW JOBS AND INCOME PROGRAM

58.1(15) Purpose
58.2(15) Definitions
58.3(15) Agreement prerequisites
58.4(15) Program benefits
58.5(15) Limitation on incentives
58.6(15) Application
58.7(15) Eligibility requirements
58.8(15) Ineligibility
58.9(15) Application
58.10(15) Department and board action
58.11(15) Agreement
58.12 Reserved
58.13(15) Compliance monitoring; notice of noncompliance and penalties
58.14(15) Repayment
58.15(15) Amendments
58.16(81GA,HF868) Applicability of new jobs and income program after July 1, 2005

CHAPTER 59
ENTERPRISE ZONE (EZ) PROGRAM

59.1(15E) Purpose and administrative procedures
59.2(15E) Definitions
59.3(15E) Enterprise zone certification
59.4(15E) Enterprise zone commission
59.5(15E) Eligibility and negotiations
59.6(15E) Eligible business
59.7 Reserved
59.8(15E) Eligible housing business
59.9 Reserved
59.10(15E) Commission review of businesses' applications
59.11(15E) Other commission responsibilities
59.12(15E) Department action on eligible applications
59.13 and 59.14 Reserved
59.15(15E) Applicability on or after July 1, 2014

CHAPTER 60
ENTREPRENEURIAL VENTURES
ASSISTANCE (EVA) PROGRAM

60.1(15) Purpose and administrative procedures
60.2(15) Definitions
60.3(15) Eligibility requirements
60.4(15) Financial assistance
60.5(15) Technical assistance
60.6(15) Application process
60.7(15) Review criteria
60.8 and 60.9 Reserved
60.10(15,83GA,SF344) Applicability of EVA program after July 1, 2009

CHAPTER 61
PHYSICAL INFRASTRUCTURE ASSISTANCE PROGRAM (PIAP)

61.1(15E) Purpose and administrative procedures
61.2(15E) Eligible activities

61.3(15E) Eligibility requirements
61.4(15E) Application procedures
61.5(15E) Application review criteria, performance measures
61.6 Reserved
61.7(15E) Forms of assistance available; award amount
61.8 Reserved
61.9(15E) Applicability of PIAP program after July 1, 2009

CHAPTER 62
COGENERATION PILOT PROGRAM

62.1(80GA,HF391) Purpose
62.2(80GA,HF391) Eligible activities
62.3(80GA,HF391) Eligibility requirements
62.4(80GA,HF391) Application procedures
62.5(80GA,HF391) Application review
62.6(80GA,HF391) Award process
62.7(80GA,HF391) Annual progress report

CHAPTER 63
UNIVERSITY-BASED RESEARCH UTILIZATION PROGRAM

63.1(80GA,HF692,HF683) Purpose
63.2(80GA,HF692,HF683) Definitions
63.3(80GA,HF692,HF683) Business eligibility
63.4(80GA,HF692,HF683) Program benefits
63.5(80GA,HF692,HF683) Funding appropriation to the regents university
63.6(80GA,HF692,HF683) Business application
63.7(80GA,HF692,HF683) Application and award process
63.8(80GA,HF692,HF683) Program administration

CHAPTER 64
NEW CAPITAL INVESTMENT PROGRAM

64.1(80GA,HF677) Purpose
64.2(80GA,HF677) Definitions
64.3(80GA,HF677) Applying for benefits
64.4(80GA,HF677) Benefits
64.5(80GA,HF677) Agreement, compliance, and repayment provisions
64.6(80GA,HF677) Amendments
64.7(80GA,HF677) Other benefits
64.8(81GA,HF868) Applicability of new capital investment program after July 1, 2005

CHAPTER 65
BROWNFIELD AND GRAYFIELD REDEVELOPMENT

65.1(15) Purpose
65.2(15) Definitions
65.3(15) Eligible applicants
65.4(15) Eligible forms of assistance and limitations
65.5(15) Repayment to economic development authority
65.6(15) General procedural overview
65.7(15) Application to the brownfield redevelopment program—agreements
65.8(15) Application to the redevelopment tax credits program—registration of projects—agreements
65.9(15) Application review criteria
65.10(15) Administration of awards

65.11(15) Redevelopment tax credit
65.12(15) Review, approval, and repayment requirements of redevelopment tax credit

CHAPTER 66
ASSISTIVE DEVICE TAX CREDIT
66.1(78GA,ch1194) Purpose
66.2(78GA,ch1194) Definitions
66.3(78GA,ch1194) Eligibility criteria
66.4(78GA,ch1194) Application process
66.5(78GA,ch1194) Review, decision and award process
66.6(78GA,ch1194) Certification
66.7(78GA,ch1194) Monitoring and misuse of funds
66.8(78GA,ch1194) Tax credit

CHAPTER 67
LIFE SCIENCE ENTERPRISES
67.1(78GA,ch1197) Purpose
67.2(78GA,ch1197) Definitions
67.3(78GA,ch1197) Filing of notice of intent
67.4(78GA,ch1197) Filing of life science enterprise plan
67.5(78GA,ch1197) Review by board
67.6(78GA,ch1197) Life science enterprise land ownership exemption
67.7(78GA,ch1197) Amendment of plan
67.8(78GA,ch1197) Successor enterprise
67.9(78GA,ch1197) Filing

CHAPTER 68
HIGH QUALITY JOBS PROGRAM (HQJP)
68.1(15) Administrative procedures and definitions
68.2(15) Eligibility requirements
68.3(15) Application process and review
68.4(15) Tax incentives
68.5(15) Project completion assistance

CHAPTER 69
LOAN AND CREDIT GUARANTEE PROGRAM
69.1(15E,81GA,HF868) Purpose
69.2(15E,81GA,HF868) Definitions
69.3(15E,81GA,HF868) Application and review process
69.4(15E,81GA,HF868) Application approval or rejection
69.5(15E,81GA,HF868) Terms and conditions
69.6(15E,81GA,HF868) Administrative costs and program fees
69.7(15E,81GA,HF868) Administration of guarantees
69.8(15E,83GA,SF344) Applicability of LCG program after July 1, 2009

CHAPTER 70
PORT AUTHORITY GRANT PROGRAM
70.1(81GA,HF2782) Purpose
70.2(81GA,HF2782) Definitions
70.3(81GA,HF2782) Program procedures
70.4(81GA,HF2782) Eligibility
70.5(81GA,HF2782) Application and review criteria
70.6(81GA,HF2782) Monitoring, reporting and follow-up

CHAPTER 71
TARGETED JOBS WITHHOLDING TAX CREDIT PROGRAM

71.1(403) Definitions
71.2(403) Eligibility requirements
71.3(403) Pilot project city application process and review
71.4(403) Withholding agreements
71.5(403) Project approval
71.6(403) Reporting requirements
71.7(403) Applicability

CHAPTER 72
IOWA EXPORT TRADE ASSISTANCE PROGRAM

72.1(78GA,ch197) Purpose
72.2(78GA,ch197) Definitions
72.3(78GA,ch197) Eligible applicants
72.4(78GA,ch197) Eligible reimbursements
72.5(78GA,ch197) Applications for assistance
72.6(78GA,ch197) Selection process
72.7(78GA,ch197) Limitations
72.8(78GA,ch197) Forms

CHAPTER 73
Reserved

CHAPTER 74
GROW IOWA VALUES FINANCIAL ASSISTANCE PROGRAM

74.1(83GA,SF344) Purpose and administrative procedures
74.2(83GA,SF344) 130 percent wage component
74.3(83GA,SF344) 100 percent wage component
74.4(83GA,SF344) Entrepreneurial component
74.5(83GA,SF344) Infrastructure component
74.6(83GA,SF344) Value-added agriculture component
74.7(83GA,SF344) Disaster recovery component
74.8(15) Applicability of the grow Iowa values financial assistance program on or after July 1, 2012

CHAPTER 75
OPPORTUNITIES AND THREATS PROGRAM

75.1(83GA,SF344) Purpose
75.2(83GA,SF344) Administrative procedures
75.3(83GA,SF344) Eligible applicants
75.4(83GA,SF344) Review criteria
75.5(83GA,SF344) Award criteria
75.6(15) Applicability of the opportunities and threats program on or after July 1, 2012

CHAPTER 76
AGGREGATE TAX CREDIT LIMIT FOR
CERTAIN ECONOMIC DEVELOPMENT PROGRAMS

76.1(15) Authority
76.2(15) Purpose
76.3(15) Definitions
76.4(15) Tax credit cap—exceeding the cap—reallocation of declinations
76.5(15) Programs subject to the cap

76.6(15) Allocating the tax credit cap
76.7 Reserved
76.8(15) Reporting to the department of revenue

CHAPTER 77
SITE DEVELOPMENT PROGRAM

DIVISION I
GENERAL PROVISIONS

77.1(15E) Purposes
77.2(15E) Authority
77.3(15E) Definitions
77.4 to 77.10 Reserved

DIVISION II
CERTIFICATE OF READINESS

77.11(15E) Eligibility
77.12(15E) Application; review; approval
77.13(15E) Evaluation criteria
77.14(15E) Certificate of readiness
77.15 to 77.20 Reserved

DIVISION III
CONSULTATION

77.21(15E) Consultation

CHAPTER 78
SMALL BUSINESS DISASTER RECOVERY FINANCIAL ASSISTANCE PROGRAM

DIVISION I
2008 NATURAL DISASTER SMALL BUSINESS DISASTER RECOVERY FINANCIAL ASSISTANCE PROGRAM

78.1(15) Purpose
78.2(15) Definitions
78.3(15) Distribution of funds to administrative entities
78.4(15) Eligible business
78.5(15) Eligible program activities; maximum amount of assistance
78.6(15) Allowable types of assistance to eligible businesses
78.7(15) Program administration and reporting
78.8 to 78.10 Reserved

DIVISION II
2010 IOWANS HELPING IOWANS BUSINESS ASSISTANCE PROGRAM

78.11(15) Purpose
78.12(15) Definitions
78.13(15) Eligible business
78.14(15) Eligible program activities; maximum amount of assistance
78.15(15) Distribution of funds; application
78.16(15) Form of assistance available to eligible businesses
78.17(15) Grants to administrative entities
78.18(15) Award; acceptance

CHAPTER 79
DISASTER RECOVERY BUSINESS RENTAL ASSISTANCE PROGRAM

79.1(15) Purpose
79.2(15) Definitions
79.3(15) Eligible business; application review
79.4(15) Eligible program activities; maximum amount of assistance

79.5(15) Distribution of funds to administrative entities
79.6(15) Program administration; reporting requirements

CHAPTER 80
IOWA SMALL BUSINESS LOAN PROGRAM

80.1(83GA,SF2389) Purpose
80.2(83GA,SF2389) Authority
80.3(83GA,SF2389) Definitions
80.4(83GA,SF2389) Administrator
80.5(83GA,SF2389) General loan terms
80.6(83GA,SF2389) Eligibility
80.7(83GA,SF2389) Application
80.8(83GA,SF2389) Application review
80.9(83GA,SF2389) Recommendation; loan agreement
80.10(83GA,SF2389) Repayment
80.11(83GA,SF2389) Default

CHAPTER 81
RENEWABLE CHEMICAL PRODUCTION TAX CREDIT PROGRAM

81.1(15) Purpose
81.2(15) Definitions
81.3(15) Eligibility requirements
81.4(15) Application process and review
81.5(15) Agreement
81.6(15) Renewable chemical production tax credit
81.7(15) Claiming the tax credit
81.8(15) Process to add building block chemicals
81.9(15) Additional information—confidentiality—annual report

CHAPTERS 82 to 100
Reserved

PART V
INNOVATION AND COMMERCIALIZATION ACTIVITIES

CHAPTER 101
MISSION AND RESPONSIBILITIES

101.1(15) Mission
101.2(15) Responsibilities

CHAPTER 102
ENTREPRENEUR INVESTMENT AWARDS PROGRAM

102.1(15E) Authority
102.2(15E) Purpose
102.3(15E) Definitions
102.4(15E) Program description, application procedures, and delegation of functions
102.5(15E) Program funding
102.6(15E) Eligibility requirements and competitive scoring process
102.7(15E) Contract and report information required

CHAPTER 103
INFORMATION TECHNOLOGY TRAINING PROGRAM

103.1(15,83GA,SF142) Authority—program termination and transition
103.2(15,83GA,SF142) Purpose
103.3(15,83GA,SF142) Definitions

103.4(15,83GA,SF142) Program funding
103.5(15,83GA,SF142) Matching funds requirement
103.6(15,83GA,SF142) Use of program funds
103.7(15,83GA,SF142) Eligible business
103.8(15,83GA,SF142) Ineligible business
103.9(15,83GA,SF142) Eligible employee
103.10(15,83GA,SF142) Ineligible employee
103.11(15,83GA,SF142) Application and review process
103.12(15,83GA,SF142) Application scoring criteria
103.13(15,83GA,SF142) Contract and reporting

CHAPTER 104
INNOVATIVE BUSINESSES INTERNSHIP PROGRAM

104.1(15) Authority
104.2(15) Purpose
104.3(15) Definitions
104.4(15) Program funding
104.5(15) Eligible business
104.6(15) Ineligible business
104.7(15) Eligible students
104.8(15) Ineligible students
104.9(15) Application submittal and review process
104.10(15) Application content and other requirements
104.11(15) Selection process
104.12(15) Application scoring criteria
104.13(15) Contract and reporting

CHAPTER 105
DEMONSTRATION FUND

105.1(15) Authority
105.2(15) Purpose
105.3(15) Definitions
105.4(15) Project funding
105.5(15) Matching funds requirement
105.6(15) Eligible applicants
105.7(15) Ineligible applicants
105.8(15) Application and review process
105.9(15) Application selection criteria
105.10(15) Contract and reporting

CHAPTER 106
SMALL BUSINESS INNOVATION RESEARCH AND TECHNOLOGY
TRANSFER OUTREACH PROGRAM

106.1(15) Authority
106.2(15) Purpose and goals
106.3(15) Definitions
106.4(15) Program description, application procedures, and delegation of functions
106.5(15) Program funding
106.6(15) Eligibility requirements
106.7(15) Agreement and report information required

CHAPTER 107
TARGETED INDUSTRIES NETWORKING FUND

107.1(82GA,ch122) Authority—fund termination and transition
107.2(82GA,ch122) Purpose
107.3(82GA,ch122) Definitions
107.4(82GA,ch122) Program funding
107.5(82GA,ch122) Eligible applicants
107.6(82GA,ch122) Application and review process
107.7(82GA,ch122) Application selection criteria
107.8(82GA,ch122) Contract and reporting

CHAPTER 108
ACCELERATION AND DEVELOPMENT OF INNOVATIVE IDEAS AND BUSINESSES

108.1(15) Authority
108.2(15) Purpose and description of program components
108.3(15) Definitions
108.4(15) Program description, application procedures, and delegation of functions
108.5(15) Program funding
108.6(15) Contract and report information required

CHAPTER 109
TARGETED INDUSTRIES CAREER AWARENESS FUND

109.1(82GA,ch122) Authority—fund termination and transition
109.2(82GA,ch122) Purpose
109.3(82GA,ch122) Definitions
109.4(82GA,ch122) Program funding
109.5(82GA,ch122) Matching funds requirement
109.6(82GA,ch122) Eligible applicants
109.7(82GA,ch122) Application and review process
109.8(82GA,ch122) Application selection criteria
109.9(82GA,ch122) Contract and reporting

CHAPTER 110
STEM INTERNSHIP PROGRAM

110.1(15,85GA,ch1132,86GA,SF510) Authority
110.2(15,85GA,ch1132,86GA,SF510) Purpose
110.3(15,85GA,ch1132,86GA,SF510) Definitions
110.4(15,85GA,ch1132,86GA,SF510) Program funding and disbursement
110.5(15,85GA,ch1132,86GA,SF510) Eligible employers
110.6(15,85GA,ch1132,86GA,SF510) Ineligible employers
110.7(15,85GA,ch1132,86GA,SF510) Eligible students
110.8(15,85GA,ch1132,86GA,SF510) Ineligible students
110.9(15,85GA,ch1132,86GA,SF510) Application submittal and review process
110.10(15,85GA,ch1132,86GA,SF510) Application content and other requirements
110.11(15,85GA,ch1132,86GA,SF510) Award process
110.12(15,85GA,ch1132,86GA,SF510) Application scoring criteria
110.13(15,85GA,ch1132,86GA,SF510) Contract and reporting

CHAPTER 111
SUPPLY CHAIN DEVELOPMENT PROGRAM

111.1(15,83GA,SF142) Authority—program termination and transition
111.2(15,83GA,SF142) Purpose
111.3(15,83GA,SF142) Definitions

111.4(15,83GA,SF142) Program funding
111.5(15,83GA,SF142) Matching funds requirement
111.6(15,83GA,SF142) Eligible applicants
111.7(15,83GA,SF142) Ineligible applicants
111.8(15,83GA,SF142) Application process
111.9(15,83GA,SF142) Application selection criteria
111.10(15,83GA,SF142) Intellectual property
111.11(15,83GA,SF142) Contract and reporting

CHAPTERS 112 and 113
Reserved

CHAPTER 114
IOWA INNOVATION COUNCIL

114.1(15) Authority
114.2(15) Purpose
114.3(15) Definitions
114.4(15) Iowa innovation council funding
114.5(15) Council membership
114.6(15) Responsibilities and deliverables
114.7(15) Executive committee
114.8(15) Application and review process for board-appointed council members
114.9(15) Voting
114.10(15) Meetings and commitment of time
114.11(15) Nonattendance
114.12(15) Council work groups
114.13(15) Reporting

CHAPTER 115
TAX CREDITS FOR INVESTMENTS IN QUALIFYING BUSINESSES AND COMMUNITY-BASED SEED CAPITAL FUNDS

115.1(15E) Tax credits for investments in qualifying businesses and community-based seed capital funds
115.2(15E) Definitions
115.3(15E) Cash investments required
115.4(15E) Applying for an investment tax credit
115.5(15E) Verification of qualifying businesses and community-based seed capital funds
115.6(15E) Approval, issuance and distribution of investment tax credits
115.7(15E) Claiming the tax credits
115.8(15E) Notification to the department of revenue
115.9(15E) Rescinding tax credits
115.10(15E) Additional information—confidentiality—annual report

CHAPTER 116
TAX CREDITS FOR INVESTMENTS IN CERTIFIED INNOVATION FUNDS

116.1(15E) Tax credit for investments in certified innovation funds
116.2(15E) Definitions
116.3(15E) Certification of innovation funds
116.4(15E) Maintenance, reporting, and revocation of certification
116.5(15E) Application for the investment tax credit certificate
116.6(15E) Approval, issuance and distribution of investment tax credits
116.7(15E) Transferability of the tax credit
116.8(15E) Vested right in the tax credit

116.9(15E) Claiming the tax credits
116.10(15E) Notification to the department of revenue
116.11(15E) Additional information

CHAPTER 117
SSBCI DEMONSTRATION FUND

117.1(84GA,HF590) Authority
117.2(84GA,HF590) Purposes, goals, and promotion
117.3(84GA,HF590) Definitions
117.4(84GA,HF590) Project funding
117.5(84GA,HF590) Leverage of financial assistance required
117.6(84GA,HF590) Eligible applicants
117.7(84GA,HF590) Ineligible applicants
117.8(84GA,HF590) Application and review process
117.9(84GA,HF590) Application selection criteria
117.10(84GA,HF590) Contract and reporting

CHAPTER 118
STRATEGIC INFRASTRUCTURE PROGRAM

118.1(15) Authority
118.2(15) Purpose
118.3(15) Definitions
118.4(15) Program description, disbursement of funds, and contract administration
118.5(15) Program eligibility and application requirements
118.6(15) Application submittal and review process
118.7(15) Application scoring criteria
118.8(15) Notice of award and reporting

CHAPTERS 119 to 162
Reserved

PART VI
ADMINISTRATION DIVISION

CHAPTER 163
DIVISION RESPONSIBILITIES

163.1(15) Mission
163.2(15) Structure

CHAPTER 164
USE OF MARKETING LOGO

164.1(15) Purpose and limitation
164.2(15) Definitions
164.3(15) Guidelines
164.4(15) Review and approval of applications
164.5(15) Licensing agreement; use of logo
164.6(15) Denial or suspension of use of logo
164.7(15) Request for hearing
164.8(15) Requests for information

CHAPTER 165
ALLOCATION OF GROW IOWA VALUES FUND

165.1(15G,83GA,SF344) Purpose
165.2(15G,83GA,SF344) Definitions
165.3(15G,83GA,SF344) Grow Iowa values fund (2009)

165.4(15G,83GA,SF344) Allocation of annual appropriation for grow Iowa values fund moneys—$50M
165.5(15G,83GA,SF344) Board allocation of other moneys in fund
165.6(15G,83GA,SF344) Annual fiscal year allocations by board
165.7(15) Applicability of the grow Iowa values financial assistance program on or after July 1, 2012

CHAPTERS 166 to 170
Reserved

PART VII
ADDITIONAL APPLICATION REQUIREMENTS AND PROCEDURES

CHAPTER 171
SUPPLEMENTAL CREDIT OR POINTS
171.1(15A) Applicability
171.2(15A) Brownfield areas, blighted areas and distressed areas
171.3(15A) Good neighbor agreements
171.4(82GA,HF647) Iowa great places agreements

CHAPTER 172
ENVIRONMENTAL LAW COMPLIANCE; VIOLATIONS OF LAW
172.1(15A) Environmental law compliance
172.2(15A) Violations of law

CHAPTER 173
STANDARD DEFINITIONS
173.1(15) Applicability
173.2(15) Definitions

CHAPTER 174
WAGE, BENEFIT, AND INVESTMENT REQUIREMENTS
174.1(15) Applicability
174.2(15) Qualifying wage threshold calculations
174.3(15) Qualifying wage threshold requirements—prior to July 1, 2009
174.4 Reserved
174.5(15) Qualifying wage threshold requirements—on or after July 1, 2009, and on or before June 30, 2012
174.6(15) Qualifying wage threshold requirements—effective on or after July 1, 2014
174.7(15) Job obligations
174.8(15) Benefit requirements—prior to July 1, 2009
174.9(15) Sufficient benefits requirement—on or after July 1, 2009
174.10(15) Capital investment, qualifying investment for tax credit programs, and investment qualifying for tax credits

CHAPTER 175
APPLICATION REVIEW AND APPROVAL PROCEDURES
175.1(15) Applicability
175.2(15) Application procedures for programs administered by the authority
175.3(15) Standard program requirements
175.4(15) Review and approval of applications
175.5(15) Local match requirements for project awards

CHAPTERS 176 to 186
Reserved

PART VIII
LEGAL AND COMPLIANCE

CHAPTER 187
CONTRACTING

187.1(15) Applicability
187.2(15) Contract required
187.3(15) Project completion date and maintenance period completion date
187.4(15) Contract and award amendment approval procedures
187.5(15) Default
187.6(15) Compliance cost fees

CHAPTER 188
CONTRACT COMPLIANCE AND JOB COUNTING

188.1(15) Applicability
188.2(15) Contract compliance
188.3(15) Job counting and tracking
188.4(15) Business's employment base
188.5(15) Job counting using base employment analysis
188.6(15) Wage determination for contract compliance purposes

CHAPTER 189
ANNUAL REPORTING

189.1(15) Annual reporting by businesses required (for period ending June 30)
189.2(15) January 31 report by authority to legislature

CHAPTERS 190 to 194
Reserved

PART IX
UNIFORM PROCEDURES: RECORDS, RULE MAKING, DECLARATORY ORDERS, RULE WAIVERS

CHAPTER 195
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

195.1(17A,22) Statement of policy, purpose and scope of chapter
195.2(17A,22) Definitions
195.3(17A,22) Requests for access to records
195.4(17A,22) Access to confidential records
195.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination
195.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
195.7(17A,22) Consent to disclosure by the subject of a confidential record
195.8(17A,22) Notice to suppliers of information
195.9(17A,22) Disclosures without the consent of the subject
195.10(17A,22) Routine use
195.11(17A,22) Consensual disclosure of confidential records
195.12(17A,22) Release to subject
195.13(17A,22) Availability of records
195.14(17A,22) Personally identifiable information
195.15(17A,22) Other groups of records

CHAPTER 196
DEPARTMENT PROCEDURE FOR RULE MAKING

196.1(17A)	Applicability
196.2(17A)	Advice on possible rules before notice of proposed rule adoption
196.3(17A)	Public rule-making docket
196.4(17A)	Notice of proposed rule making
196.5(17A)	Public participation
196.6(17A)	Regulatory analysis
196.7(17A,25B)	Fiscal impact statement
196.8(17A)	Time and manner of rule adoption
196.9(17A)	Variance between adopted rule and published notice of proposed rule adoption
196.10(17A)	Exemptions from public rule-making procedures
196.11(17A)	Concise statement of reasons
196.12(17A)	Contents, style, and form of rule
196.13(17A)	Department rule-making record
196.14(17A)	Filing of rules
196.15(17A)	Effectiveness of rules prior to publication
196.16(17A)	Review by department of rules
196.17(17A)	Written criticisms of department rules

CHAPTER 197
PETITION FOR RULE MAKING

197.1(17A)	Petition for rule making
197.2(17A)	Briefs
197.3(17A)	Inquiries
197.4(17A)	Department consideration

CHAPTER 198
PETITION FOR DECLARATORY ORDER

198.1(17A)	Petition for declaratory order
198.2(17A)	Notice of petition
198.3(17A)	Intervention
198.4(17A)	Briefs
198.5(17A)	Inquiries
198.6(17A)	Service and filing of petitions and other papers
198.7(17A)	Consideration
198.8(17A)	Action on petition
198.9(17A)	Refusal to issue order
198.10(17A)	Contents of declaratory order—effective date
198.11(17A)	Copies of orders
198.12(17A)	Effect of a declaratory order

CHAPTER 199
UNIFORM WAIVER AND VARIANCE RULES

199.1(ExecOrd11)	Applicability
199.2(ExecOrd11)	Director/board discretion
199.3(ExecOrd11)	Requester's responsibilities in filing a waiver or variance petition
199.4(ExecOrd11)	Notice
199.5(ExecOrd11)	Department responsibilities regarding petition for waiver or variance
199.6(ExecOrd11)	Public availability
199.7(ExecOrd11)	Voiding or cancellation
199.8(ExecOrd11)	Violations

199.9(ExecOrd11) Defense
199.10(ExecOrd11,17A) Appeals

PART X
COMMUNITY ATTRACTION AND INVESTMENT PROGRAMS

CHAPTER 200
REINVESTMENT DISTRICTS PROGRAM

200.1(15J) Purpose
200.2(15J) Definitions
200.3(15J) Program overview
200.4(15J) Preapplication process
200.5(15J) Program eligibility and application requirements
200.6(15J) Application scoring and determination of benefits
200.7(15J) Final application and approval process
200.8(15J) Adoption of ordinance and use of funds
200.9(15J) Plan amendments and reporting
200.10(15J) Cessation of deposits, district dissolution, and revenue rules

CHAPTERS 201 to 210
Reserved

CHAPTER 211
COMMUNITY ATTRACTION AND
TOURISM DEVELOPMENT (CATD) PROGRAMS

DIVISION I
GENERAL PROVISIONS

211.1(15F) Purpose
211.2(15F) Definitions
211.3(15F) Program components
211.4(15F) Eligible applicants
211.5(15F) Eligible projects and forms of assistance
211.6(15F) Ineligible projects
211.7(15F) Threshold application requirements
211.8(15F) Application review criteria
211.9(15F) Application procedure
211.10(15F) Administration
211.11 to 211.49 Reserved

DIVISION II
COMMUNITY ATTRACTION AND TOURISM (CAT) FUND

211.50(15F) Applicability
211.51(15F) Allocation of funds
211.52 to 211.100 Reserved

DIVISION III
RIVER ENHANCEMENT COMMUNITY ATTRACTION AND TOURISM (RECAT) FUND

211.101(15F) Applicability
211.102(15F) Allocation of funds

DIVISION IV
CAT AND RECAT WAIVERS

211.103(15F) Procedures for waiver of local or private matching moneys

CHAPTER 212
VISION IOWA PROGRAM

212.1(15F) Purpose
212.2(15F) Definitions
212.3(15F) Allocation of funds
212.4(15F) Eligible applicants
212.5(15F) Eligible projects and forms of assistance
212.6(15F) Ineligible projects
212.7(15F) Threshold application requirements
212.8(15F) Application review criteria
212.9(15F) Application procedure
212.10(15F) Administration of awards

CHAPTER 213
VISION IOWA BOARD: UNIFORM WAIVER
AND VARIANCE RULES

213.1(17A,ExecOrd11) Applicability
213.2(17A,ExecOrd11) Board discretion
213.3(17A,ExecOrd11) Requester's responsibilities in filing a waiver or variance petition
213.4(17A,ExecOrd11) Notice
213.5(17A,ExecOrd11) Board responsibilities regarding petition for waiver or variance
213.6(17A,ExecOrd11) Public availability
213.7(17A,ExecOrd11) Voiding or cancellation
213.8(17A,ExecOrd11) Violations
213.9(17A,ExecOrd11) Defense
213.10(17A,ExecOrd11) Appeals

CHAPTER 214
ENHANCE IOWA BOARD

214.1(15F) Definitions
214.2(15F) Enhance Iowa board
214.3(15F) Authority duties

CHAPTER 215
SPORTS TOURISM PROGRAM

215.1(15F) Definitions
215.2(15F) Eligible applicants
215.3(15F) Eligible projects
215.4(15F) Threshold application requirements
215.5(15F) Application process
215.6(15F) Administration

CHAPTERS 216 to 299
Reserved

PART XI
RENEWABLE FUEL INFRASTRUCTURE BOARD

CHAPTERS 300 to 310
Reserved

CHAPTER 311
RENEWABLE FUEL INFRASTRUCTURE BOARD—ORGANIZATION

311.1(15G) Definitions
311.2(15G) Renewable fuel infrastructure board

CHAPTER 312
RENEWABLE FUEL INFRASTRUCTURE PROGRAM FOR
RETAIL MOTOR FUEL SITES

312.1(15G) Purpose
312.2(15G) Eligible applicants

CHAPTER 313
RENEWABLE FUEL INFRASTRUCTURE PROGRAM FOR
BIODIESEL TERMINAL GRANTS

313.1(15G) Purpose
313.2(15G) Eligible applicants

CHAPTER 314
RENEWABLE FUEL INFRASTRUCTURE PROGRAM ADMINISTRATION

314.1(15G) Allocation of awards by congressional district
314.2(15G) Form of award available; award amount
314.3(15G) Application process
314.4(15G) Review process
314.5(15G) Contract administration

CHAPTERS 315 to 399
Reserved

PART XII
ENERGY DIVISION

CHAPTER 400
RULES APPLICABLE TO PART XII

400.1(84GA,HF590) Definitions
400.2(84GA,HF590) Purpose, administrative information, and implementation

CHAPTER 401
ADMINISTRATION OF FINANCIAL ASSISTANCE

401.1(84GA,HF590) Purpose
401.2(84GA,HF590) Appropriations
401.3(84GA,HF590) Control of fund assets
401.4(84GA,HF590) Allocation of fund moneys
401.5(84GA,HF590) Eligible applicants
401.6(84GA,HF590) Eligibility criteria for financial assistance
401.7(84GA,HF590) Forms of assistance
401.8(84GA,HF590) Application process
401.9(84GA,HF590) Confidentiality
401.10(84GA,HF590) Contents of full application
401.11(84GA,HF590) Selection criteria
401.12(84GA,HF590) Contract administration

CHAPTER 402
ENERGY EFFICIENCY COMMUNITY GRANT PROGRAM

402.1(84GA,HF590) Purpose
402.2(84GA,HF590) Definitions

402.3(84GA,HF590) Requests for applications
402.4(84GA,HF590) Geographic distribution
402.5(84GA,HF590) Criteria for review
402.6(84GA,HF590) Project approval and award of funds

CHAPTERS 403 to 409
Reserved

PART XIII
IOWA BROADBAND DEPLOYMENT GOVERNANCE BOARD

CHAPTER 410
Reserved

CHAPTER 411
IOWA BROADBAND DEPLOYMENT PROGRAM

411.1(83GA,SF376) Purpose
411.2(83GA,SF376) Definitions
411.3(83GA,SF376) Eligible applicants
411.4(83GA,SF376) Forms of assistance
411.5(83GA,SF376) Threshold application requirements
411.6(83GA,SF376) Application process
411.7(83GA,SF376) Application review procedures
411.8(83GA,SF376) Administration of awards

CHAPTER 412
FAIR INFORMATION PRACTICES, WAIVER AND VARIANCE,
AND PETITION FOR RULE MAKING

412.1(83GA,SF376) Fair information practices
412.2(83GA,SF376) Waiver and variance
412.3(83GA,SF376) Petition for rule making

CHAPTER 106
SMALL BUSINESS INNOVATION RESEARCH AND TECHNOLOGY TRANSFER OUTREACH PROGRAM

261—106.1(15) Authority. The authority for adopting rules establishing the small business innovation research and technology transfer outreach program under this chapter is provided in 2012 Iowa Acts, House File 2473, division II.
[**ARC 0611C**, IAB 2/20/13, effective 3/27/13]

261—106.2(15) Purpose and goals.

106.2(1) The purpose of the small business innovation research and technology transfer outreach program is to assist businesses with applications to the federal Small Business Innovation Research and Small Business Technology Transfer Programs. The program will provide financial and technical assistance to businesses for that purpose.

106.2(2) The goals of providing this assistance are to increase the number of successful grant and contract proposals in the state, increase the amount of funds awarded in the state, stimulate subsequent investment by industry, venture capital, and other sources, and encourage businesses to commercialize promising technologies.
[**ARC 0611C**, IAB 2/20/13, effective 3/27/13; **ARC 3195C**, IAB 7/5/17, effective 8/9/17]

261—106.3(15) Definitions. As used in this chapter, unless the context otherwise requires:

"Applicant" means a business applying to the authority for assistance under the program.

"Assistance" means technical and financial assistance available under the program.

"Authority" means the economic development authority created in Iowa Code section 15.105.

"Award" means SBIR/STTR grant and contract funds awarded by federal agencies.

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

"Committee" means the technology commercialization committee established by the board pursuant to 261—Chapter 1.

"Corporation" means the Iowa innovation corporation created pursuant to Iowa Code section 15.107.

"Financial assistance" means assistance provided only from the funds, rights, and assets legally available to the authority and includes but is not limited to assistance in the form of grants, loans, forgivable loans, and royalty agreements.

"Innovative business" means the same as defined in Iowa Code section 15E.52(1)*"c."*

"Program" means the small business innovation research and technology transfer outreach program established pursuant to Iowa Code section 15.411.

"SBIR/STTR" means the federal Small Business Innovation Research and Small Business Technology Transfer Programs.
[**ARC 0611C**, IAB 2/20/13, effective 3/27/13; **ARC 3195C**, IAB 7/5/17, effective 8/9/17]

261—106.4(15) Program description, application procedures, and delegation of functions.

106.4(1) *General description.* The program provides technical assistance and financial assistance to applicants seeking SBIR/STTR funding. All awards of financial assistance must ultimately be approved by the board, after a recommendation by the committee, and an agreement must be entered into with the authority before moneys will be disbursed.

106.4(2) *Program components and activities.* The program has two primary components, a technical assistance component and a financial assistance component, both of which are intended to increase the number of phase I, phase II, and fast track SBIR/STTR awards for Iowa businesses. The corporation shall be the primary provider of technical assistance to applicants and shall also work with the authority to provide financial assistance.

a. In providing technical assistance, the corporation shall develop a pre-proposal submission component that facilitates expert peer reviews from commercial reviewers with in-depth market

knowledge. The resulting reviews should provide the applicant with a set of recommendations and tips for troubleshooting SBIR/STTR proposals. The corporation shall ensure that the applicants develop and implement recommendations for their proposals based on industry best practices.

b. The corporation shall provide services that include the following:

(1) Detailed outlines and other tools to make the drafting of a proposal and other accompanying documentation less daunting.

(2) Reviews and critiques of iterative drafts to improve the structure and narrative of both the research and the commercialization plans.

(3) Evaluation of budgets and budget justifications to produce stronger applications and avoid "leaving money on the table."

(4) Assistance with the electronic registrations and the application submission process.

c. In working with the authority to provide financial assistance, the corporation shall perform the functions delegated pursuant to subrule 106.4(4).

106.4(3) *Application and award procedures.* Eligible applicants may submit applications to the authority for financial assistance. To be eligible, an applicant must meet the requirements in rule 261—106.6(15). The applications will receive an initial review to confirm program eligibility before being sent to the committee for a recommendation on funding. The committee will provide its recommendation to the board for a final determination on the provision of financial assistance. The board may approve, deny, or defer each application for financial assistance under the program. The board will consider applications for financial assistance on a first-come, first-served basis. If the board approves funding for an applicant, the authority will prepare a required agreement specifying the terms and conditions under which the financial assistance is to be provided to the applicant.

106.4(4) *Delegation of certain administrative functions to the corporation.* The authority will delegate certain administrative functions of the program to the corporation. The functions that will be delegated are:

a. The initial application review process, including an analysis of whether the applicant meets all requirements of eligibility under the program and a recommendation on the amount of financial assistance to be provided and under what terms and conditions.

b. The tracking and monitoring of the applicant's SBIR/STTR application progress as well as the eventual outcome. The corporation shall report annually to the authority on the results of the program.

c. The tracking and monitoring of agreement terms and conditions for applicants receiving financial assistance under the program.

d. The provision of technical assistance as described in subrule 106.4(2).

106.4(5) *Administrative functions not delegated.* The authority will retain, and not delegate, the performance of the following functions: (1) the final determination as to whether to approve, deny, or defer an award of financial assistance; (2) the disbursal of moneys provided for in an award of financial assistance; (3) the final determination as to whether there is a default in the terms of an agreement entered into under the program, including all decisions regarding appropriate remedies for such a default; and (4) any other function not clearly delegated to the corporation pursuant to subrule 106.4(4).

[**ARC 0611C**, IAB 2/20/13, effective 3/27/13; **ARC 3195C**, IAB 7/5/17, effective 8/9/17]

261—106.5(15) Program funding.

106.5(1) *Program funding limitation.* Each year, the authority allocates moneys for purposes of the programs listed in Iowa Code section 15.411, including this program. The amount allocated each year will depend on the amount appropriated to the authority by the general assembly. The authority may allocate other funds to the program as such funds may from time to time become available.

106.5(2) *Individual applicant limitation.* The authority will not award more than $100,000 in financial assistance to any applicant for any individual federal SBIR/STTR award.

[**ARC 0611C**, IAB 2/20/13, effective 3/27/13; **ARC 3195C**, IAB 7/5/17, effective 8/9/17]

261—106.6(15) Eligibility requirements. In order to be eligible for financial or technical assistance under the program, an applicant must meet the following requirements:

106.6(1) The applicant must be an innovative business.

106.6(2) The applicant must have a reasonable likelihood of receiving SBIR/STTR grant funds, must be likely to stimulate subsequent investment by industry, venture capital, and other sources, and must be likely to commercialize some promising technology.
[**ARC 0611C**, IAB 2/20/13, effective 3/27/13; **ARC 3195C**, IAB 7/5/17, effective 8/9/17]

261—106.7(15) Agreement and report information required.

106.7(1) *Agreement required.* An applicant awarded financial assistance under the program shall enter into an agreement with the authority for the receipt of such funds. The authority will include in the agreement all terms and conditions for receipt of the funds, including any terms recommended by the corporation. The tracking and monitoring of the agreement terms will be delegated to the corporation. The corporation shall provide regular reports to the authority on the progress of the applicant and on the results of the tracking and monitoring. The authority will make the final determination as to compliance with the terms of the agreement and as to whether and when to disburse funds to the applicant.

106.7(2) *Reporting information required.* An applicant may be required to submit all information necessary for the authority to compile a report on the results of the program. The authority will include terms in the required agreement effectuating this requirement.
[**ARC 0611C**, IAB 2/20/13, effective 3/27/13; **ARC 3195C**, IAB 7/5/17, effective 8/9/17]

These rules are intended to implement Iowa Code section 15.411.

[Filed ARC 0611C (Notice ARC 0408C, IAB 10/17/12), IAB 2/20/13, effective 3/27/13]
[Filed ARC 3195C (Notice ARC 2938C, IAB 2/15/17), IAB 7/5/17, effective 8/9/17]

EDUCATION DEPARTMENT[281]

Created by 1986 Iowa Acts, chapter 1245, section 1401.
Prior to 9/7/88, see Public Instruction Department[670]
(Replacement pages for 9/7/88 published in 9/21/88 IAC)

TITLE I
GENERAL INFORMATION—
DEPARTMENT OPERATIONS

CHAPTER 1
ORGANIZATION AND OPERATION

1.1(17A,256) State board of education
1.2(17A,256) Student member of state board of education
1.3(17A,256) Director of education
1.4(17A,256) Department of education

CHAPTER 2
AGENCY PROCEDURE FOR RULE MAKING AND PETITIONS FOR RULE MAKING
(Uniform Rules)

2.1(17A) Applicability
2.2(17A) Advice on possible rules before notice of proposed rule adoption
2.3(17A) Public rule-making docket
2.4(17A) Notice of proposed rule making
2.5(17A) Public participation
2.6(17A) Regulatory analysis
2.7(17A,25B) Fiscal impact statement
2.8(17A) Time and manner of rule adoption
2.9(17A) Variance between adopted rule and published notice of proposed rule adoption
2.10(17A) Exemptions from public rule-making procedures
2.11(17A) Concise statement of reasons
2.12(17A) Contents, style, and form of rule
2.13(17A) Agency rule-making record
2.14(17A) Filing of rules
2.15(17A) Effectiveness of rules prior to publication
2.16(17A) General statements of policy
2.17(17A) Review by agency of rules
2.18(17A) Petition for rule making
2.19(17A) Inquiries

CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)

3.1(17A) Petition for declaratory order
3.2(17A) Notice of petition
3.3(17A) Intervention
3.4(17A) Briefs
3.5(17A) Inquiries
3.6(17A) Service and filing of petitions and other papers
3.7(17A) Consideration
3.8(17A) Action on petition
3.9(17A) Refusal to issue order
3.10(17A) Contents of declaratory order—effective date
3.11(17A) Copies of orders
3.12(17A) Effect of a declaratory order

CHAPTER 4
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

4.1(17A,ExecOrd11) Definitions
4.2(17A,ExecOrd11) Scope of chapter
4.3(17A,ExecOrd11) Applicability of chapter
4.4(17A,ExecOrd11) Criteria for waiver
4.5(17A,ExecOrd11) Filing of petition
4.6(17A,ExecOrd11) Content of petition
4.7(17A,ExecOrd11) Additional information
4.8(17A,ExecOrd 11) Notice
4.9(17A,ExecOrd11) Hearing procedures
4.10(17A,ExecOrd11) Ruling
4.11(17A,ExecOrd11) Public availability
4.12(17A,ExecOrd11) Summary reports
4.13(17A,ExecOrd11) Cancellation
4.14(17A,ExecOrd11) Violations
4.15(17A,ExecOrd11) Defense
4.16(17A,ExecOrd11) Judicial review
4.17(17A,ExecOrd11) Exception

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

5.1(256) Definitions
5.3(256) Requests for access to records
5.6(256) Procedure by which additions, dissents, or objections may be entered into certain records
5.9(256) Disclosures without the consent of the subject
5.10(256) Routine use
5.11(256) Consensual disclosure of confidential records
5.12(256) Release to a subject
5.13(256) Availability of records
5.14(256) Personally identifiable information
5.15(256) Other groups of records
5.16(256) Applicability

CHAPTER 6
APPEAL PROCEDURES

6.1(290) Scope of appeal
6.2(256,290,17A) Definitions
6.3(290,17A) Manner of appeal
6.4(17A) Continuances
6.5(17A) Intervention
6.6(17A) Motions
6.7(17A) Disqualification
6.8(290) Subpoena of witnesses and costs
6.9(17A) Discovery
6.10(17A) Consolidation—severance
6.11(17A) Waiver of procedures
6.12(17A) Appeal hearing
6.13 Reserved
6.14(17A) Ex parte communication
6.15(17A) Record

6.16(17A) Recording costs
6.17(290,17A) Decision and review
6.18(290) Finality of decision
6.19(17A) Default
6.20(17A) Application for rehearing of final decision
6.21(17A) Rehearing
6.22(17A) Emergency adjudicative proceedings
6.23(256,17A) Additional requirements for specific programs

CHAPTER 7
CRITERIA FOR GRANTS

7.1(256,17A) Purpose
7.2(256,17A) Definitions
7.3(256,17A) Requirements
7.4(256,17A) Review process
7.5(290,17A) Appeal of grant denial or termination

CHAPTERS 8 to 10
Reserved

TITLE II
ACCREDITED SCHOOLS AND SCHOOL DISTRICTS

CHAPTER 11
UNSAFE SCHOOL CHOICE OPTION

11.1(PL107-110) Purpose
11.2(PL107-110) Definitions
11.3(PL107-110) Whole school option
11.4(PL107-110) Individual student option
11.5(PL107-110) District reporting

CHAPTER 12
GENERAL ACCREDITATION STANDARDS

DIVISION I
GENERAL STANDARDS

12.1(256) General standards

DIVISION II
DEFINITIONS

12.2(256) Definitions

DIVISION III
ADMINISTRATION

12.3(256) Administration

DIVISION IV
SCHOOL PERSONNEL

12.4(256) School personnel

DIVISION V
EDUCATION PROGRAM

12.5(256) Education program

DIVISION VI
ACTIVITY PROGRAM

12.6(256) Activity program

DIVISION VII
STAFF DEVELOPMENT

12.7(256,284,284A) Professional development

DIVISION VIII
ACCOUNTABILITY

12.8(256) Accountability for student achievement

DIVISION IX
EXEMPTION REQUEST PROCESS

12.9(256) General accreditation standards exemption request

DIVISION X
INDEPENDENT ACCREDITING AGENCIES

12.10(256) Independent accrediting agencies

CHAPTER 13
Reserved

CHAPTER 14
SCHOOL HEALTH SERVICES

14.1 and 14.2 Reserved
14.3(256) School district and accredited nonpublic school stock epinephrine auto-injector voluntary supply
14.4(256,280) Severability

CHAPTER 15
USE OF ONLINE LEARNING AND TELECOMMUNICATIONS FOR INSTRUCTION BY SCHOOLS

15.1(256) Purpose
15.2(256) Definitions

DIVISION I
USE OF TELECOMMUNICATIONS FOR INSTRUCTION BY SCHOOLS

15.3(256) Interactivity
15.4(256) Course eligibility

15.5(256) Teacher preparation and accessibility
15.6(256) School responsibilities

DIVISION II
ONLINE LEARNING OFFERED BY A SCHOOL DISTRICT

15.7(256) School district responsibilities
15.8(256) Prohibition regarding open enrollment
15.9(256) Special education services

DIVISION III
IOWA LEARNING ONLINE (ILO)

15.10(256) Appropriate applications of ILO coursework
15.11(256) Inappropriate applications of ILO coursework; criteria for waivers
15.12(256) School and school district responsibilities
15.13(256) Department responsibilities
15.14(256) Enrollment in an ILO course

CHAPTER 16
STATEWIDE VOLUNTARY PRESCHOOL PROGRAM

16.1(256C) Purpose
16.2(256C) Definitions
16.3(256C) Preschool program standards
16.4(256C) Collaboration requirements
16.5(256C) Applications for funding
16.6(256C) Application process
16.7(256C) Award contracts
16.8(256C) Contract termination
16.9(256C) Criteria for applications for funding
16.10(256C) Appeal of application denial or termination
16.11(256C) Finance
16.12(256C) Transportation
16.13(256C) Accountability requirements
16.14(256C) Monitoring
16.15(256C) Open enrollment not applicable

CHAPTER 17
OPEN ENROLLMENT

17.1(282) Intent and purpose
17.2(282) Definitions
17.3(282) Application process
17.4(282) Filing after the March 1 deadline—good cause
17.5(282) Filing after the March 1 deadline—harassment or serious health condition
17.6(282) Restrictions to open enrollment requests
17.7(282) Open enrollment for kindergarten
17.8(282) Requirements applicable to parents/guardians and students
17.9(282) Transportation
17.10(282) Method of finance
17.11(282) Special education students
17.12 Reserved
17.13(282) Applicability
17.14(282) Voluntary diversity plans or court-ordered desegregation plans

CHAPTER 18
SCHOOL FEES

18.1(256)	Policy
18.2(256)	Fee policy
18.3(256)	Eligibility for waiver, partial waiver or temporary waiver of student fees
18.4(256)	Fees covered
18.5(256)	Effective date

CHAPTERS 19 and 20
Reserved

TITLE III
COMMUNITY COLLEGES

CHAPTER 21
COMMUNITY COLLEGES

DIVISION I
APPROVAL STANDARDS

21.1(260C)	Definitions
21.2(260C)	Administration
21.3	Reserved
21.4(260C)	Curriculum and evaluation
21.5(260C)	Library or learning resource center
21.6(260C)	Student services
21.7(260C)	Laboratories, equipment and supplies
21.8(260C)	Physical plant
21.9(260C)	Nonreimbursable facilities
21.10 to 21.19	Reserved

DIVISION II
COMMUNITY COLLEGE ENERGY APPROPRIATIONS

21.20 to 21.29	Reserved

DIVISION III
INSTRUCTIONAL COURSE FOR DRINKING DRIVERS

21.30(321J)	Purpose
21.31(321J)	Course
21.32(321J)	Tuition fee established
21.33(321J)	Administrative fee established
21.34(321J)	Advisory committee

DIVISION IV
JOBS NOW CAPITALS ACCOUNT

21.35 to 21.44	Reserved

DIVISION V
STATE COMMUNITY COLLEGE FUNDING PLAN

21.45(260C)	Purpose

DIVISION VI
INTERCOLLEGIATE ATHLETIC COMPETITION

21.46 to 21.56	Reserved

DIVISION VII
QUALITY INSTRUCTIONAL CENTER INITIATIVE

21.57 to 21.63	Reserved

DIVISION VIII
PROGRAM AND ADMINISTRATIVE SHARING INITIATIVE

21.64 to 21.71	Reserved

DIVISION IX
APPRENTICESHIP PROGRAM

21.72(260C) Purpose
21.73(260C) Definitions
21.74(260C) Apprenticeship programs

DIVISION X
MISCELLANEOUS PROVISIONS

21.75(260C,82GA,SF358) Used motor vehicle dealer education program

CHAPTER 22
SENIOR YEAR PLUS PROGRAM

DIVISION I
GENERAL PROVISIONS

22.1(261E) Scope
22.2(261E) Student eligibility
22.3(261E) Teacher eligibility, responsibilities
22.4(261E) Institutional eligibility, responsibilities
22.5 Reserved

DIVISION II
DEFINITIONS

22.6(261E) Definitions

DIVISION III
ADVANCED PLACEMENT PROGRAM

22.7(261E) School district obligations
22.8(261E) Obligations regarding registration for advanced placement examinations
22.9 and 22.10 Reserved

DIVISION IV
CONCURRENT ENROLLMENT PROGRAM

22.11(261E) Applicability
22.12 and 22.13 Reserved

DIVISION V
POSTSECONDARY ENROLLMENT OPTIONS PROGRAM

22.14(261E) Availability
22.15(261E) Notification
22.16(261E) Student eligibility
22.17(261E) Eligible postsecondary courses
22.18(261E) Application process
22.19(261E) Credits
22.20(261E) Transportation
22.21(261E) Tuition payments
22.22(261E) Tuition reimbursements and adjustments
22.23 Reserved

DIVISION VI
CAREER ACADEMIES

22.24(261E) Career academies
22.25 Reserved

DIVISION VII
REGIONAL ACADEMIES

22.26(261E) Regional academies
22.27(261E) Waivers for certain regional academies

DIVISION VIII
INTERNET-BASED AND ICN COURSEWORK

22.28(261E) Internet-based coursework
22.29(261E) ICN-based coursework
22.30 and 22.31 Reserved

DIVISION IX
PROJECT LEAD THE WAY

22.32(261E) Project lead the way

CHAPTER 23
ADULT EDUCATION AND LITERACY PROGRAMS

23.1(260C) Definitions
23.2(260C) State planning
23.3(260C) Program administration
23.4(260C) Career pathways
23.5(260C) Student eligibility
23.6(260C) Qualification of staff
23.7(260C) High-quality professional development
23.8(260C) Performance and accountability

CHAPTER 24
COMMUNITY COLLEGE ACCREDITATION

24.1(260C) Purpose
24.2(260C) Scope
24.3(260C) Definitions
24.4(260C) Accreditation components and criteria—Higher Learning Commission
24.5(260C) Accreditation components and criteria—additional state standards
24.6(260C) Accreditation process

CHAPTER 25
PATHWAYS FOR ACADEMIC CAREER AND EMPLOYMENT PROGRAM;
GAP TUITION ASSISTANCE PROGRAM

DIVISION I
GENERAL PROVISIONS

25.1(260H,260I) Scope
25.2(260H,260I) Definitions
25.3 to 25.10 Reserved

DIVISION II
PATHWAYS FOR ACADEMIC CAREER AND EMPLOYMENT (PACE) PROGRAM

25.11(260H) Purpose
25.12(260H) Target populations
25.13(260H) Eligibility criteria for projects
25.14(260H) Program component requirements
25.15(260H) Pipeline program
25.16(260H) Career pathways and bridge curriculum development program
25.17(260H) Pathway navigators
25.18(260H) Regional industry sector partnerships
25.19 Reserved

DIVISION III
GAP TUITION ASSISTANCE PROGRAM

25.20(260I) Purpose
25.21(260I) Applicants for tuition assistance
25.22(260I) Eligible costs

25.23(260I) Eligible certificate programs
25.24(260I) Initial assessment
25.25(260I) Program interview
25.26(260I) Participation requirements
25.27(260I) Oversight

TITLE IV
DRIVER AND SAFETY EDUCATION

CHAPTER 26
Reserved

CHAPTER 27
WORKFORCE TRAINING AND ECONOMIC DEVELOPMENT FUNDS

27.1(260C) Purpose
27.2(260C) Definitions
27.3(260C) Funds allocation
27.4(260C) Community college workforce and economic development fund plans and progress reports
27.5(260C) Use of funds
27.6(260C) Prior approval
27.7(260C) Annual plan and progress report approval
27.8(260C) Options upon default or noncompliance

CHAPTERS 28 to 30
Reserved

TITLE V
NONTRADITIONAL STUDENTS

CHAPTER 31
PRIVATE INSTRUCTION AND DUAL ENROLLMENT

31.1(299,299A) Purpose and definitions
31.2(299) Reports as to competent private instruction
31.3(299,299A) Duties of privately retained licensed practitioners
31.4(299,299A) Duties of licensed practitioners, home school assistance program
31.5(299A) School district duties related to competent private instruction
31.6(299A) Dual enrollment
31.7(299) Open enrollment
31.8(299A) Baseline evaluation and annual assessment
31.9(299A) Reporting assessment results
31.10(299A) Special education students
31.11(299,299A) Independent private instruction
31.12(299,299A) Miscellaneous provisions

CHAPTER 32
HIGH SCHOOL EQUIVALENCY DIPLOMA

32.1(259A) Test
32.2(259A) By whom administered
32.3(259A) Minimum score
32.4(259A) Effectiveness of test scores
32.5(259A) Retest
32.6(259A) Application fee
32.7(259A) Diploma, transcript, verification fees
32.8(259A) Admission to testing

CHAPTER 33
EDUCATING THE HOMELESS

33.1(256) Purpose
33.2(256) Definitions
33.3(256) Responsibilities of the board of directors
33.4(256) School records; student transfers
33.5(256) Immunization requirements
33.6(256) Waiver of fees and charges encouraged
33.7(256) Waiver of enrollment requirements encouraged; placement
33.8(256) Residency of homeless child or youth
33.9(256) Dispute resolution
33.10(256) Transportation of homeless children and youth
33.11(256) School services

CHAPTER 34
FUNDING FOR CHILDREN RESIDING IN STATE INSTITUTIONS
OR MENTAL HEALTH INSTITUTES

34.1(218) Scope
34.2(218) Definitions
34.3(218) General principles
34.4(218) Notification
34.5(218) Program submission and approval
34.6(218) Budget submission and approval
34.7(218) Payments
34.8(218) Payments to the AEA
34.9(218) Contracting for services
34.10(218) Accounting for average daily attendance
34.11(218) Accounting for actual program costs
34.12(218) Audit
34.13(218) Hold-harmless provision
34.14(218,256B,34CFR300) AEA services
34.15(218,233A,261C) Postsecondary credit courses

CHAPTER 35
EDUCATIONAL STANDARDS AND PROGRAM REQUIREMENTS FOR CHILDREN'S
RESIDENTIAL FACILITIES

35.1(282) Scope
35.2(282) Intent
35.3(282) Definitions
35.4(282) Establishing an appropriate educational program
35.5(282) Display of notices; fees
35.6(282) Provision of appropriate educational services
35.7(282) Reporting

TITLE VI
INTERSCHOLASTIC COMPETITION

CHAPTER 36
EXTRACURRICULAR INTERSCHOLASTIC COMPETITION

36.1(280) Definitions
36.2(280) Registered organizations
36.3(280) Filings by organizations
36.4(280) Executive board
36.5(280) Federation membership

36.6(280) Salaries
36.7(280) Expenses
36.8(280) Financial report
36.9(280) Bond
36.10(280) Audit
36.11(280) Examinations by auditors
36.12(280) Access to records
36.13(280) Appearance before state board
36.14(280) Interscholastic athletics
36.15(280) Eligibility requirements
36.16(280) Executive board review
36.17(280) Appeals to director
36.18(280) Organization policies
36.19(280) Eligibility in situations of district organization change
36.20(280) Cooperative student participation

CHAPTER 37
EXTRACURRICULAR ATHLETIC ACTIVITY
CONFERENCE FOR MEMBER SCHOOLS

37.1(280) Policy and purpose
37.2(280) Initial responsibility
37.3(280) Complaint to the director, department of education
37.4(280) Mediation
37.5(280) Resolution or recommendation of the mediation team
37.6(280) Decision
37.7(280) Effective date of the decision

CHAPTERS 38 to 40
Reserved

TITLE VII
SPECIAL EDUCATION

CHAPTER 41
SPECIAL EDUCATION

DIVISION I
PURPOSE AND APPLICABILITY

41.1(256B,34CFR300) Purposes
41.2(256B,34CFR300) Applicability of this chapter

DIVISION II
DEFINITIONS

41.3(256B,34CFR300) Act
41.4(256B,273) Area education agency
41.5(256B,34CFR300) Assistive technology device
41.6(256B,34CFR300) Assistive technology service
41.7(256B,34CFR300) Charter school
41.8(256B,34CFR300) Child with a disability
41.9(256B,34CFR300) Consent
41.10(256B,34CFR300) Core academic subjects
41.11(256B,34CFR300) Day; business day; school day
41.12(256B,34CFR300) Educational service agency
41.13(256B,34CFR300) Elementary school
41.14(256B,34CFR300) Equipment

41.15(256B,34CFR300) Evaluation
41.16(256B,34CFR300) Excess costs
41.17(256B,34CFR300) Free appropriate public education
41.18(256B,34CFR300) Highly qualified special education teachers
41.19(256B,34CFR300) Homeless children
41.20(256B,34CFR300) Include
41.21(256B,34CFR300) Indian and Indian tribe
41.22(256B,34CFR300) Individualized education program
41.23(256B,34CFR300) Individualized education program team
41.24(256B,34CFR300) Individualized family service plan
41.25(256B,34CFR300) Infant or toddler with a disability
41.26(256B,34CFR300) Institution of higher education
41.27(256B,34CFR300) Limited English proficient
41.28(256B,34CFR300) Local educational agency
41.29(256B,34CFR300) Native language
41.30(256B,34CFR300) Parent
41.31(256B,34CFR300) Parent training and information center
41.32(256B,34CFR300) Personally identifiable
41.33(256B,34CFR300) Public agency; nonpublic agency; agency
41.34(256B,34CFR300) Related services
41.35(34CFR300) Scientifically based research
41.36(256B,34CFR300) Secondary school
41.37(34CFR300) Services plan
41.38(34CFR300) Secretary
41.39(256B,34CFR300) Special education
41.40(34CFR300) State
41.41(256B,34CFR300) State educational agency
41.42(256B,34CFR300) Supplementary aids and services
41.43(256B,34CFR300) Transition services
41.44(34CFR300) Universal design
41.45(256B,34CFR300) Ward of the state
41.46 to 41.49 Reserved
41.50(256B,34CFR300) Other definitions associated with identification of eligible individuals
41.51(256B,34CFR300) Other definitions applicable to this chapter
41.52 to 41.99 Reserved

DIVISION III
RULES APPLICABLE TO THE STATE AND TO ALL AGENCIES

41.100(256B,34CFR300) Eligibility for assistance
41.101(256B,34CFR300) Free appropriate public education (FAPE)
41.102(256B,34CFR300) Limitation—exceptions to FAPE for certain ages
41.103(256B,34CFR300) FAPE—methods and payments
41.104(256B,34CFR300) Residential placement
41.105(256B,34CFR300) Assistive technology
41.106(256B,34CFR300) Extended school year services
41.107(256B,34CFR300) Nonacademic services
41.108(256B,34CFR300) Physical education
41.109(256B,34CFR300) Full educational opportunity goal (FEOG)
41.110(256B,34CFR300) Program options
41.111(256B,34CFR300) Child find
41.112(256B,34CFR300) Individualized education programs (IEPs)
41.113(256B,34CFR300) Routine checking of hearing aids and external components of surgically implanted medical devices

41.114(256B,34CFR300) Least restrictive environment (LRE)
41.115(256B,34CFR300) Continuum of alternative services and placements
41.116(256B,34CFR300) Placements
41.117(256B,34CFR300) Nonacademic settings
41.118(256B,34CFR300) Children in public or private institutions
41.119(256B,34CFR300) Technical assistance and training activities
41.120(256B,34CFR300) Monitoring activities
41.121(256B,34CFR300) Procedural safeguards
41.122(256B,34CFR300) Evaluation
41.123(256B,34CFR300) Confidentiality of personally identifiable information
41.124(256B,34CFR300) Transition of children from the Part C program to preschool programs
41.125 to 41.128 Reserved
41.129(256B,34CFR300) Responsibility regarding children in private schools
41.130(256,256B,34CFR300) Definition of parentally placed private school children with disabilities
41.131(256,256B,34CFR300) Child find for parentally placed private school children with disabilities
41.132(256,256B,34CFR300) Provision of services for parentally placed private school children with disabilities: basic requirement
41.133(256,256B,34CFR300) Expenditures
41.134(256,256B,34CFR300) Consultation
41.135(256,256B,34CFR300) Written affirmation
41.136(256,256B,34CFR300) Compliance
41.137(256,256B,34CFR300) Equitable services determined
41.138(256,256B,34CFR300) Equitable services provided
41.139(256,256B,34CFR300) Location of services and transportation
41.140(256,256B,34CFR300) Due process complaints and state complaints
41.141(256,256B,34CFR300) Requirement that funds not benefit a private school
41.142(256,256B,34CFR300) Use of personnel
41.143(256,256B,34CFR300) Separate classes prohibited
41.144(256,256B,34CFR300) Property, equipment, and supplies
41.145(256B,34CFR300) Applicability of rules 281—41.146(256B,34CFR300) to 281—41.147(256B,34CFR300)
41.146(256B,34CFR300) Responsibility of department
41.147(256B,34CFR300) Implementation by department
41.148(256B,34CFR300) Placement of children by parents when FAPE is at issue
41.149(256B,34CFR300) SEA responsibility for general supervision
41.150 Reserved
41.151(256B,34CFR300) Adoption of state complaint procedures
41.152(256B,34CFR300) Minimum state complaint procedures
41.153(256B,34CFR300) Filing a complaint
41.154(256B,34CFR300) Methods of ensuring services
41.155(256B,34CFR300) Hearings relating to AEA or LEA eligibility
41.156(256B,34CFR300) Personnel qualifications
41.157 to 41.161 Reserved
41.162(256B,34CFR300) Supplementation of state, local, and other federal funds
41.163(256B,34CFR300) Maintenance of state financial support
41.164 Reserved
41.165(256B,34CFR300) Public participation
41.166(256B,34CFR300) Rule of construction
41.167(256B,34CFR300) State advisory panel
41.168(256B,34CFR300) Advisory panel membership
41.169(256B,34CFR300) Advisory panel duties
41.170(256B,34CFR300) Suspension and expulsion rates

41.171 Reserved
41.172(256B,34CFR300) Access to instructional materials
41.173(256B,34CFR300) Overidentification and disproportionality
41.174(256B,34CFR300) Prohibition on mandatory medication
41.175 Reserved
41.176(256B) Special school provisions
41.177(256B) Facilities
41.178(256B) Materials, equipment and assistive technology
41.179 to 41.185 Reserved
41.186(256B,34CFR300) Assistance under other federal programs
41.187(256B) Research, innovation, and improvement
41.188 to 41.199 Reserved

DIVISION IV
LEA AND AEA ELIGIBILITY, IN GENERAL

41.200(256B,34CFR300) Condition of assistance
41.201(256B,34CFR300) Consistency with state policies
41.202(256B,34CFR300) Use of amounts
41.203(256B,34CFR300) Maintenance of effort
41.204(256B,34CFR300) Exception to maintenance of effort
41.205(256B,34CFR300) Adjustment to local fiscal efforts in certain fiscal years
41.206(256B,34CFR300) Schoolwide programs under Title I of the ESEA
41.207(256B,34CFR300) Personnel development
41.208(256B,34CFR300) Permissive use of funds
41.209(256B,34CFR300) Treatment of charter schools and their students
41.210(256B,34CFR300) Purchase of instructional materials
41.211(256B,34CFR300) Information for department
41.212(256B,34CFR300) Public information
41.213(256B,34CFR300) Records regarding migratory children with disabilities
41.214 to 41.219 Reserved
41.220(256B,34CFR300) Exception for prior local plans
41.221(256B,34CFR300) Notification of AEA or LEA or state agency in case of ineligibility
41.222(256B,34CFR300) AEA or LEA and state agency compliance
41.223(256B,34CFR300) Joint establishment of eligibility
41.224(256B,34CFR300) Requirements for jointly establishing eligibility
41.225 Reserved
41.226(256B,34CFR300) Early intervening services
41.227 Reserved
41.228(256B,34CFR300) State agency eligibility
41.229(256B,34CFR300) Disciplinary information
41.230(256B,34CFR300) SEA flexibility
41.231 to 41.299 Reserved

DIVISION V
EVALUATION, ELIGIBILITY, IEPs, AND PLACEMENT DECISIONS

41.300(256B,34CFR300) Parental consent and participation
41.301(256B,34CFR300) Full and individual initial evaluations
41.302(256B,34CFR300) Screening for instructional purposes is not evaluation
41.303(256B,34CFR300) Reevaluations
41.304(256B,34CFR300) Evaluation procedures
41.305(256B,34CFR300) Additional requirements for evaluations and reevaluations
41.306(256B,34CFR300) Determination of eligibility
41.307(256B,34CFR300) Specific learning disabilities
41.308(256B,34CFR300) Additional group members

41.309(256B,34CFR300) Determining the existence of a specific learning disability
41.310(256B,34CFR300) Observation
41.311(256B,34CFR300) Specific documentation for the eligibility determination
41.312(256B,34CFR300) General education interventions
41.313(256B,34CFR300) Systematic problem-solving process
41.314(256B,34CFR300) Progress monitoring and data collection
41.315 to 41.319 Reserved
41.320(256B,34CFR300) Definition of individualized education program
41.321(256B,34CFR300) IEP team
41.322(256B,34CFR300) Parent participation
41.323(256B,34CFR300) When IEPs must be in effect
41.324(256B,34CFR300) Development, review, and revision of IEP
41.325(256B,34CFR300) Private school placements by public agencies
41.326(256B,34CFR300) Other rules concerning IEPs
41.327(256B,34CFR300) Educational placements
41.328(256B,34CFR300) Alternative means of meeting participation
41.329 to 41.399 Reserved

DIVISION VI
ADDITIONAL RULES RELATED TO AEAs, LEAs, AND SPECIAL EDUCATION

41.400(256B,34CFR300) Shared responsibility
41.401(256B,34CFR300) Licensure (certification)
41.402(256B,273,34CFR300) Authorized personnel
41.403(256B) Paraprofessionals
41.404(256B) Policies and procedures required of all public agencies
41.405(256B) Special health services
41.406(256B) Additional requirements of LEAs
41.407(256B,273,34CFR300) Additional requirements of AEAs
41.408(256B,273,34CFR300) Instructional services
41.409(256B,34CFR300) Support services
41.410(256B,34CFR300) Itinerant services
41.411(256B,34CFR300) Related services, supplementary aids and services
41.412(256B,34CFR300) Transportation
41.413(256,256B,34CFR300) Additional rules relating to accredited nonpublic schools
41.414 to 41.499 Reserved

DIVISION VII
PROCEDURAL SAFEGUARDS

41.500(256B,34CFR300) Responsibility of SEA and other public agencies
41.501(256B,34CFR300) Opportunity to examine records; parent participation in meetings
41.502(256B,34CFR300) Independent educational evaluation
41.503(256B,34CFR300) Prior notice by the public agency; content of notice
41.504(256B,34CFR300) Procedural safeguards notice
41.505(256B,34CFR300) Electronic mail
41.506(256B,34CFR300) Mediation
41.507(256B,34CFR300) Filing a due process complaint
41.508(256B,34CFR300) Due process complaint
41.509(256B,34CFR300) Model forms
41.510(256B,34CFR300) Resolution process
41.511(256B,34CFR300) Impartial due process hearing
41.512(256B,34CFR300) Hearing rights
41.513(256B,34CFR300) Hearing decisions
41.514(256B,34CFR300) Finality of decision
41.515(256B,34CFR300) Timelines and convenience of hearings

41.516(256B,34CFR300) Civil action
41.517(256B,34CFR300) Attorneys' fees
41.518(256B,34CFR300) Child's status during proceedings
41.519(256B,34CFR300) Surrogate parents
41.520(256B,34CFR300) Transfer of parental rights at age of majority
41.521 to 41.529 Reserved
41.530(256B,34CFR300) Authority of school personnel
41.531(256B,34CFR300) Determination of setting
41.532(256B,34CFR300) Appeal
41.533(256B,34CFR300) Placement during appeals and mediations
41.534(256B,34CFR300) Protections for children not determined eligible for special education and related services
41.535(256B,34CFR300) Referral to and action by law enforcement and judicial authorities
41.536(256B,34CFR300) Change of placement because of disciplinary removals
41.537(256B,34CFR300) State enforcement mechanisms
41.538 to 41.599 Reserved

DIVISION VIII
MONITORING, ENFORCEMENT, CONFIDENTIALITY, AND PROGRAM INFORMATION

41.600(256B,34CFR300) State monitoring and enforcement
41.601(256B,34CFR300) State performance plans and data collection
41.602(256B,34CFR300) State use of targets and reporting
41.603(256B,34CFR300) Department review and determination regarding public agency performance
41.604(256B,34CFR300) Enforcement
41.605(256B,34CFR300) Withholding funds
41.606(256B,34CFR300) Public attention
41.607 Reserved
41.608(256B,34CFR300) State enforcement
41.609(256B,34CFR300) State consideration of other state or federal laws
41.610(256B,34CFR300) Confidentiality
41.611(256B,34CFR300) Definitions
41.612(256B,34CFR300) Notice to parents
41.613(256B,34CFR300) Access rights
41.614(256B,34CFR300) Record of access
41.615(256B,34CFR300) Records on more than one child
41.616(256B,34CFR300) List of types and locations of information
41.617(256B,34CFR300) Fees
41.618(256B,34CFR300) Amendment of records at parent's request
41.619(256B,34CFR300) Opportunity for a hearing
41.620(256B,34CFR300) Result of hearing
41.621(256B,34CFR300) Hearing procedures
41.622(256B,34CFR300) Consent
41.623(256B,34CFR300) Safeguards
41.624(256B,34CFR300) Destruction of information
41.625(256B,34CFR300) Children's rights
41.626(256B,34CFR300) Enforcement
41.627 to 41.639 Reserved
41.640(256B,34CFR300) Annual report of children served—report requirement
41.641(256B,34CFR300) Annual report of children served—information required in the report
41.642(256B,34CFR300) Data reporting
41.643(256B,34CFR300) Annual report of children served—certification
41.644(256B,34CFR300) Annual report of children served—criteria for counting children
41.645(256B,34CFR300) Annual report of children served—other responsibilities of the SEA

41.646(256B,34CFR300) Disproportionality
41.647 to 41.699 Reserved

DIVISION IX
ALLOCATIONS BY THE SECRETARY TO THE STATE

41.700 to 41.703 Reserved
41.704(256B,34CFR300) State-level activities
41.705(256B,34CFR300) Subgrants to AEAs
41.706 to 41.799 Reserved

DIVISION X
PRESCHOOL GRANTS FOR CHILDREN WITH DISABILITIES

41.800(256B,34CFR300) General rule
41.801 and 41.802 Reserved
41.803(256B,34CFR300) Definition of state
41.804(256B,34CFR300) Eligibility
41.805 Reserved
41.806(256B,34CFR300) Eligibility for financial assistance
41.807 to 41.811 Reserved
41.812(256B,34CFR300) Reservation for state activities
41.813(256B,34CFR300) State administration
41.814(256B,34CFR300) Other state-level activities
41.815(256B,34CFR300) Subgrants to AEAs
41.816(256B,34CFR300) Allocations to AEAs
41.817(256B,34CFR300) Reallocation of AEA funds
41.818(256B,34CFR300) Part C of the Act inapplicable
41.819 to 41.899 Reserved

DIVISION XI
ADDITIONAL RULES CONCERNING FINANCE AND PUBLIC ACCOUNTABILITY

41.900(256B,282) Scope
41.901(256B,282) Records and reports
41.902(256B,282) Audit
41.903(256B,282) Contractual agreements
41.904(256B) Research and demonstration projects and models for special education program development
41.905(256B,273) Additional special education
41.906(256B,273,282) Extended school year services
41.907(256B,282,34CFR300,303) Program costs
41.908(256B,282) Accountability
41.909 to 41.999 Reserved

DIVISION XII
PRACTICE BEFORE MEDIATORS AND ADMINISTRATIVE LAW JUDGES

41.1000(17A,256B,290) Applicability
41.1001(17A,256B,290) Definitions
41.1002(256B,34CFR300) Special education mediation conference
41.1003(17A,256B) Procedures concerning due process complaints
41.1004(17A,256B) Participants in the hearing
41.1005(17A,256B) Convening the hearing
41.1006(17A,256B) Stipulated record hearing
41.1007(17A,256B) Evidentiary hearing
41.1008(17A,256B) Mixed evidentiary and stipulated record hearing
41.1009(17A,256B) Witnesses
41.1010(17A,256B) Rules of evidence

41.1011(17A,256B) Communications
41.1012(17A,256B) Record
41.1013(17A,256B) Decision and review
41.1014(17A,256B) Finality of decision
41.1015(256B,34CFR300) Disqualification of mediator
41.1016(17A) Correcting decisions of administrative law judges
41.1017 to 41.1099 Reserved

DIVISION XIII
ADDITIONAL RULES NECESSARY TO IMPLEMENT AND APPLY THIS CHAPTER

41.1100(256B,34CFR300) References to Code of Federal Regulations
41.1101(256B,34CFR300) Severability

CHAPTER 42
Reserved

TITLE VIII
SCHOOL TRANSPORTATION

CHAPTER 43
PUPIL TRANSPORTATION

DIVISION I
TRANSPORTATION ROUTES

43.1(285) Intra-area education agency routes
43.2(285) Interarea education agency routes

DIVISION II
PRIVATE CONTRACTORS

43.3(285) Contract required
43.4(285) Uniform charge
43.5(285) Board must be party
43.6(285) Contract with parents
43.7(285) Vehicle requirements

DIVISION III
FINANCIAL RECORDS AND REPORTS

43.8(285) Required charges
43.9(285) Activity trips deducted

DIVISION IV
USE OF SCHOOL BUSES

43.10(285) Permitted uses listed
43.11(285) Teacher transportation

DIVISION V
THE BUS DRIVER

43.12(285) Driver qualifications
43.13(285) Stability factors
43.14(285) Driver age
43.15(285) Physical fitness
43.16 Reserved
43.17(285) Insulin-dependent diabetics
43.18(285) Authorization to be carried by driver
43.19 and 43.20 Reserved
43.21(285) Experience, traffic law knowledge and driving record
43.22(321) Fee collection and distribution of funds
43.23(285) Application form
43.24(321) Authorization denials and revocations

DIVISION VI
PURCHASE OF BUSES

43.25(285) Local board procedure
43.26(285) Financing
43.27 to 43.29 Reserved

DIVISION VII
MISCELLANEOUS REQUIREMENTS

43.30(285) Semiannual inspection
43.31(285) Maintenance record
43.32(285) Drivers' schools
43.33(285) Insurance
43.34(285) Contract—privately owned buses
43.35(285) Contract—district-owned buses
43.36(285) Accident reports
43.37(285) Railroad crossings
43.38(285) Driver restrictions
43.39(285) Civil defense projects
43.40(285) Pupil instruction
43.41(285) Trip inspections
43.42(285) Loading and unloading areas
43.43(285) Communication equipment

DIVISION VIII
COMMON CARRIERS

43.44(285) Standards for common carriers

CHAPTER 44
SCHOOL BUSES

44.1(285) Requirements for manufacturers
44.2(285) School bus—type classifications
44.3(285) School bus body and chassis specifications
44.4(285) Construction of vehicles for children with mobility challenges
44.5(285) Type III vehicles
44.6(285) Repair, replacement of school bus body and chassis components following original equipment manufacture

CHAPTER 45
Reserved

CHAPTER 46
CAREER AND TECHNICAL EDUCATION

46.1(258) Federal Act accepted
46.2(258) Definitions
46.3(258) State board for career and technical education
46.4(258) Career and technical education service areas
46.5(258) Standards for career and technical education
46.6(258) Career and technical education program approval and review
46.7(258) Accreditation standards not met
46.8(258) Advisory council
46.9(258) Distribution of career and technical education funds
46.10(258) Regional career and technical education planning partnerships
46.11(258) Career academies
46.12(258) Regional centers

CHAPTER 47
Reserved

CHAPTER 48
STATEWIDE WORK-BASED LEARNING INTERMEDIARY NETWORK

48.1(256) Purpose
48.2(256) Definitions
48.3(256) Statewide work-based learning intermediary network
48.4(256) Regional work-based learning intermediary network

CHAPTER 49
INDIVIDUAL CAREER AND ACADEMIC PLAN

49.1(279) Purpose
49.2(279) Definitions
49.3(279) Individualized career and academic plan
49.4(279) Essential components
49.5(279) District plan
49.6(279) Career information and decision-making systems
49.7(279) Compliance

CHAPTER 50
Reserved

TITLE X
VETERANS' TRAINING

CHAPTER 51
APPROVAL OF ON-THE-JOB TRAINING ESTABLISHMENTS
UNDER THE MONTGOMERY G.I. BILL

51.1(256) Application
51.2(256) Content and approval of application
51.3(256) Wage schedules

CHAPTER 52
APPROVAL OF EDUCATIONAL INSTITUTIONS
FOR THE EDUCATION AND TRAINING OF ELIGIBLE VETERANS
UNDER THE MONTGOMERY G.I. BILL

52.1(256) Colleges
52.2(256) High schools
52.3 Reserved
52.4(256) Schools of Bible or theology
52.5(256) Schools of nursing
52.6(256) Hospitals
52.7(256) Schools of cosmetology
52.8(256) Schools of barbering
52.9 Reserved
52.10(256) Schools of business
52.11(256) Trade schools
52.12(256) Correspondence schools
52.13(256) Successful operation on a continuous basis
52.14(256) Nonaccredited schools
52.15(256) Evaluation standards

CHAPTERS 53 to 55
Reserved

TITLE XI
VOCATIONAL REHABILITATION EDUCATION

CHAPTER 56
IOWA VOCATIONAL REHABILITATION SERVICES

DIVISION I
SCOPE AND GENERAL PRINCIPLES

56.1(259) Responsibility of division
56.2(259) Nondiscrimination

DIVISION II
DEFINITIONS

56.3(259) Definitions

DIVISION III
ELIGIBILITY

56.4(259) Individuals who are recipients of SSD/SSI
56.5(259) Eligibility for vocational rehabilitation services
56.6(259) Other eligibility and service determinations

DIVISION IV
CASE MANAGEMENT

56.7(259) Case finding and intake
56.8(259) Case diagnosis used in case recording
56.9(259) Individualized plan for employment (IPE)

DIVISION V
SERVICES

56.10(259) Scope of services
56.11(259) Training
56.12(259) Maintenance
56.13(259) Transportation
56.14(259) Rehabilitation technology
56.15(259) Placement
56.16(259) Miscellaneous or auxiliary services
56.17(259) Facilities
56.18(259) Exceptions to payment for services
56.19(259) Exceptions to duration of services
56.20(259) Maximum rates of payment to training facilities

DIVISION VI
PURCHASING PRINCIPLES

56.21(259) Purchasing principles for job candidate-specific purchases

DIVISION VII
SUPERVISOR REVIEW, MEDIATION, HEARINGS, AND APPEALS

56.22(259) Review process
56.23(259) Supervisor review
56.24(259) Mediation
56.25(259) Hearing before impartial hearing officer

DIVISION VIII
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES

56.26(259) Collection and maintenance of records
56.27(259) Personally identifiable information
56.28(259) Other groups of records routinely available for public inspection

DIVISION IX
STATE REHABILITATION COUNCIL

56.29(259) State rehabilitation council

DIVISION X
IOWA SELF-EMPLOYMENT PROGRAM
(A/K/A ENTREPRENEURS WITH DISABILITIES PROGRAM)

56.30(259) Purpose
56.31(259) Program requirements
56.32(259) Application procedure
56.33(259) Award of technical assistance funds
56.34(259) Business plan feasibility study procedure
56.35(259) Award of financial assistance funds

CHAPTER 57
Reserved

TITLE XII
PROGRAMS ADMINISTRATION

CHAPTER 58
SCHOOL BREAKFAST AND LUNCH PROGRAM; NUTRITIONAL CONTENT STANDARDS FOR OTHER FOODS AND BEVERAGES

58.1(283A,256) Authority

DIVISION I
SCHOOL BREAKFAST AND LUNCH PROGRAM

58.2(283A) Definitions
58.3(283A) Agreement required
58.4(283A) State plan
58.5(283A) Service area defined
58.6(283A) School breakfast program
58.7(283A) School lunch program
58.8(283A) Procurement

DIVISION II
NUTRITIONAL CONTENT STANDARDS FOR OTHER FOODS AND BEVERAGES

58.9(256) Definitions
58.10(256) Scope
58.11(256) Nutritional content standards

CHAPTER 59
GIFTED AND TALENTED PROGRAMS

59.1(257) Scope and general principles
59.2(257) Definitions
59.3 Reserved
59.4(257) Program plan
59.5(257) Responsibilities of school districts
59.6(257) Responsibilities of area education agencies
59.7(257) Responsibilities of the department

CHAPTER 60
PROGRAMS FOR STUDENTS OF LIMITED ENGLISH PROFICIENCY

60.1(280) Scope
60.2(280) Definitions
60.3(280) School district responsibilities
60.4(280) Department responsibility

60.5(280) Nonpublic school participation
60.6(280) Funding

CHAPTER 61
IOWA READING RESEARCH CENTER

61.1(256) Establishment
61.2(256) Purpose
61.3(256) Intensive summer literacy program
61.4(256) First efforts of the center
61.5(256) Nature of the center's operation
61.6(256) Nature of the center's products
61.7(256) Governance and leadership of the center
61.8(256) Financing of the center
61.9(256) Annual report

CHAPTER 62
STATE STANDARDS FOR PROGRESSION IN READING

62.1(256,279) Purpose
62.2(256,279) Assessment of reading proficiency
62.3(256,279) Tools for evaluating and reevaluating reading proficiency
62.4(256,279) Identification of a student as being persistently at risk in reading
62.5(256,279) Intensive summer reading program
62.6(256,279) Successful progression for early readers
62.7(256,279) Promotion to grade four
62.8(256,279) Good-cause exemption
62.9(256,279) Ensuring continuous improvement in reading proficiency
62.10(256,279) Miscellaneous provisions

CHAPTER 63
EDUCATIONAL PROGRAMS AND SERVICES
FOR PUPILS IN JUVENILE HOMES

63.1(282) Scope
63.2(282) Definitions
63.3(282) Forms
63.4(282) Budget amendments
63.5(282) Area education agency responsibility
63.6(282) Educational program
63.7(282) Special education
63.8(282) Educational services
63.9(282) Media services
63.10(282) Other responsibilities
63.11(282) Curriculum
63.12(282) Disaster procedures
63.13(282) Maximum class size
63.14(282) Teacher certification and preparation
63.15(282) Aides
63.16(282) Accounting
63.17(282) Revenues
63.18(282) Expenditures
63.19(282) Claims
63.20(282) Audits
63.21(282) Waivers

CHAPTER 64
CHILD DEVELOPMENT COORDINATING COUNCIL

64.1(256A,279) Purpose
64.2(256A,279) Definitions
64.3(256A,279) Child development coordinating council
64.4(256A,279) Procedures
64.5(256A,279) Duties
64.6(256A,279) Eligibility identification procedures
64.7(256A,279) Primary eligibility
64.8(256A,279) Secondary eligibility
64.9(256A,279) Grant awards criteria
64.10(256A,279) Application process
64.11(256A,279) Request for proposals
64.12(256A,279) Grant process
64.13(256A,279) Award contracts
64.14(256A,279) Notification of applicants
64.15(256A,279) Grantee responsibilities
64.16(256A,279) Withdrawal of contract offer
64.17(256A,279) Evaluation
64.18(256A,279) Contract revisions and budget reversions
64.19(256A,279) Termination for convenience
64.20(256A,279) Termination for cause
64.21(256A,279) Responsibility of grantee at termination
64.22(256A,279) Appeal from terminations
64.23(256A,279) Refusal to issue ruling
64.24(256A,279) Request for Reconsideration
64.25(256A,279) Refusal to issue decision on request
64.26(256A,279) Granting a Request for Reconsideration

CHAPTER 65
PROGRAMS FOR AT-RISK EARLY ELEMENTARY STUDENTS

65.1(279) Purpose
65.2(279) Definitions
65.3(279) Eligibility identification procedures
65.4(279) Award allocation procedure
65.5(279) Award acceptance process
65.6(279) Awardee responsibilities
65.7(279) Allowable expenditures
65.8(279) Evaluation
65.9(279) Budget revisions
65.10(279) Termination for convenience
65.11(279) Termination for cause
65.12(279) Responsibility of awardee at termination
65.13(279) Appeals from terminations

CHAPTER 66
SCHOOL-BASED YOUTH SERVICES PROGRAMS

66.1(279) Scope, purpose and general principles
66.2(279) Definitions
66.3(279) Development of a program plan
66.4(279) Program plan
66.5(279) Evaluation of financial support

66.6(279) Responsibilities of area education agencies
66.7(279) Responsibilities of the department of education

CHAPTER 67
EDUCATIONAL SUPPORT PROGRAMS FOR PARENTS
OF AT-RISK CHILDREN AGED BIRTH THROUGH FIVE YEARS

67.1(279) Purpose
67.2(279) Definitions
67.3(279) Eligibility identification procedures
67.4(279) Eligibility
67.5(279) Secondary eligibility
67.6(279) Grant awards criteria
67.7(279) Application process
67.8(279) Request for proposals
67.9(279) Award contracts
67.10(279) Notification of applicants
67.11(279) Grantee responsibilities
67.12(279) Withdrawal of contract offer
67.13(279) Evaluation
67.14(279) Contract revisions
67.15(279) Termination for convenience
67.16(279) Termination for cause
67.17(279) Responsibility of grantee at termination
67.18(279) Appeal from terminations
67.19(279) Refusal to issue ruling
67.20(279) Request for Reconsideration
67.21(279) Refusal to issue decision on request
67.22(279) Granting a Request for Reconsideration

CHAPTER 68
IOWA PUBLIC CHARTER AND INNOVATION ZONE SCHOOLS

DIVISION I
GENERAL PROVISIONS

68.1(256F,83GA,SF2033) Purpose
68.2(256F,83GA,SF2033) Definitions

DIVISION II
CHARTER SCHOOLS

68.3(256F,83GA,SF2033) Application to a school board
68.4(256F,83GA,SF2033) Review process
68.5(256F,83GA,SF2033) Ongoing review by department
68.6(256F,83GA,SF2033) Renewal of charter
68.7(256F,83GA,SF2033) Revocation of charter
68.8 to 68.10 Reserved

DIVISION III
INNOVATION ZONE SCHOOLS

68.11(256F,83GA,SF2033) Application process
68.12(256F,83GA,SF2033) Review process
68.13(256F,83GA,SF2033) Ongoing review by department
68.14(256F,83GA,SF2033) Renewal of contract
68.15(256F,83GA,SF2033) Revocation of contract

CHAPTER 69
Reserved

TITLE XIII
AREA EDUCATION AGENCIES

CHAPTERS 70 and 71
Reserved

CHAPTER 72
ACCREDITATION OF AREA EDUCATION AGENCIES

72.1(273) Scope
72.2(273) Definitions
72.3(273) Accreditation components
72.4(273) Standards for services
72.5 to 72.8 Reserved
72.9(273) Comprehensive improvement plan
72.10(273) Annual budget and annual progress report
72.11(273) Comprehensive site visit

TITLE XIV
TEACHERS AND PROFESSIONAL LICENSING

CHAPTERS 73 to 76
Reserved

CHAPTER 77
STANDARDS FOR TEACHER INTERN PREPARATION PROGRAMS

77.1(256) General statement
77.2(256) Definitions
77.3(256) Institutions affected
77.4(256) Criteria for Iowa teacher intern preparation programs
77.5(256) Approval of programs
77.6(256) Periodic reports
77.7(256) Approval of program changes

TEACHER INTERN PREPARATION PROGRAM STANDARDS

77.8(256) Governance and resources standard
77.9(256) Faculty standard
77.10(256) Program of study standard
77.11(256) Assessment standard

CHAPTER 78
Reserved

CHAPTER 79
STANDARDS FOR PRACTITIONER AND ADMINISTRATOR PREPARATION PROGRAMS

DIVISION I
GENERAL STANDARDS APPLICABLE TO ALL PRACTITIONER PREPARATION PROGRAMS

79.1(256) General statement
79.2(256) Definitions
79.3(256) Institutions affected
79.4(256) Criteria for practitioner preparation programs
79.5(256) Approval of programs
79.6(256) Visiting teams

79.7(256) Periodic reports
79.8(256) Reevaluation of practitioner preparation programs
79.9(256) Approval of program changes

DIVISION II
SPECIFIC EDUCATION STANDARDS APPLICABLE TO ALL PRACTITIONER PREPARATION PROGRAMS
79.10(256) Governance and resources standard
79.11(256) Diversity standard
79.12(256) Faculty standard
79.13(256) Assessment system and unit evaluation standard

DIVISION III
SPECIFIC EDUCATION STANDARDS APPLICABLE ONLY TO INITIAL PRACTITIONER PREPARATION PROGRAMS FOR TEACHER CANDIDATES
79.14(256) Teacher preparation clinical practice standard
79.15(256) Teacher candidate knowledge, skills and dispositions standard

DIVISION IV
SPECIFIC EDUCATION STANDARDS APPLICABLE ONLY TO ADMINISTRATOR PREPARATION PROGRAMS
79.16(256) Administrator preparation clinical practice standard
79.17(256) Administrator knowledge, skills, and dispositions standard
79.18 Reserved

DIVISION V
SPECIFIC EDUCATION STANDARDS APPLICABLE ONLY TO PRACTITIONER PREPARATION PROGRAMS OTHER THAN TEACHER OR ADMINISTRATOR PREPARATION PROGRAMS
79.19(256) Purpose
79.20(256) Clinical practice standard
79.21(256) Candidate knowledge, skills and dispositions standard

CHAPTER 80
STANDARDS FOR PARAEDUCATOR PREPARATION PROGRAMS
80.1(272) General statement
80.2(272) Definitions
80.3(272) Institutions affected
80.4(272) Criteria for Iowa paraeducator preparation programs
80.5(272) Application; approval of programs
80.6(272) Periodic reports
80.7(272) Reevaluation of paraeducator preparation programs
80.8(272) Approval of program changes
80.9(272) Organizational and resource standards
80.10(272) Diversity standards
80.11(272) Faculty standards
80.12(272) Program assessment and evaluation standards
80.13(272) Clinical practice standards

CHAPTER 81
STANDARDS FOR SCHOOL BUSINESS OFFICIAL PREPARATION PROGRAMS
81.1(256) Definitions
81.2(256) Institutions eligible to provide a school business official preparation program
81.3(256) Approval of programs
81.4(256) Governance and resources standard
81.5(256) Instructor standard
81.6(256) Assessment system and institution evaluation standard
81.7(256) School business official candidate knowledge and skills standards and criteria
81.8(256) School business official mentoring program
81.9(256) Periodic reports

81.10(256) Reevaluation of school business official preparation programs
81.11(256) Approval of program changes

CHAPTER 82
STANDARDS FOR SCHOOL ADMINISTRATION MANAGER PROGRAMS

82.1(272) Definitions
82.2(272) Organizations eligible to provide a school administration manager training program
82.3(272) Approval of training programs
82.4(272) Governance and resources standard
82.5(272) Trainer and coach standard
82.6(272) Assessment system and organization evaluation standard
82.7(272) School administration manager knowledge and skills standards and criteria
82.8(272) Periodic reports
82.9(272) Reevaluation of school administration manager programs
82.10(272) Approval of program changes and flexibility of programs
82.11(272) Fees

CHAPTER 83
TEACHER AND ADMINISTRATOR QUALITY PROGRAMS

DIVISION I
GENERAL STANDARDS APPLICABLE TO BOTH ADMINISTRATOR AND TEACHER QUALITY PROGRAMS

83.1(284,284A) Purposes
83.2(284,284A) Definitions

DIVISION II
SPECIFIC STANDARDS APPLICABLE TO TEACHER QUALITY PROGRAMS

83.3(284) Mentoring and induction program for beginning teachers
83.4(284) Iowa teaching standards and criteria
83.5(284) Evaluator approval training
83.6(284) Professional development for teachers
83.7(284) Teacher quality committees

DIVISION III
SPECIFIC STANDARDS APPLICABLE TO ADMINISTRATOR QUALITY PROGRAMS

83.8(284A) Administrator quality program
83.9(284A) Mentoring and induction program for administrators
83.10(284A) Iowa school leadership standards and criteria for administrators
83.11(284A) Evaluation
83.12(284A) Professional development of administrators

CHAPTER 84
FINANCIAL INCENTIVES FOR NATIONAL BOARD CERTIFICATION

84.1(256) Purpose
84.2(256) Definitions
84.3(256) Registration fee reimbursement program
84.4(256) NBC annual award
84.5(256) Appeal of denial of a registration fee reimbursement award or an NBC annual award

CHAPTERS 85 to 93
Reserved

TITLE XV
EDUCATIONAL EXCELLENCE

CHAPTER 94
Reserved

CHAPTER 95
EQUAL EMPLOYMENT OPPORTUNITY
AND AFFIRMATIVE ACTION IN EDUCATIONAL AGENCIES

95.1(256)	Purpose
95.2(256)	Definitions
95.3(256)	Equal employment opportunity standards
95.4(256)	Duties of boards of directors
95.5(256)	Plan components
95.6(256)	Dissemination
95.7(256)	Reports

TITLE XVI
SCHOOL FACILITIES

CHAPTER 96
STATEWIDE/LOCAL OPTION SALES AND
SERVICES TAX FOR SCHOOL INFRASTRUCTURE

96.1(423E,423F)	Definitions
96.2(423E,423F)	Reports to the department
96.3(423E,423F)	Combined actual enrollment
96.4(423E,423F)	Application and certificate of need process
96.5(423E,423F)	Review process
96.6(423E,423F)	Award process
96.7(423E,423F)	Applicant responsibilities
96.8(423E,423F)	Appeal of certificate denial

CHAPTER 97
SUPPLEMENTARY WEIGHTING

97.1(257)	Definitions
97.2(257)	Supplementary weighting plan
97.3(257)	Supplementary weighting plan for at-risk students
97.4(257)	Supplementary weighting plan for a regional academy
97.5(257)	Supplementary weighting plan for whole-grade sharing
97.6(257)	Supplementary weighting plan for ICN video services
97.7(257)	Supplementary weighting plan for operational services

CHAPTER 98
FINANCIAL MANAGEMENT OF CATEGORICAL FUNDING

DIVISION I
GENERAL PROVISIONS

98.1(256,257)	Definitions
98.2(256,257)	General finance
98.3 to 98.10	Reserved

DIVISION II
APPROPRIATE USE OF BUDGETARY ALLOCATIONS

98.11(257)	Categorical and noncategorical student counts
98.12(257,299A)	Home school assistance program
98.13(256C,257)	Statewide voluntary four-year-old preschool program

98.14(257) Supplementary weighting
98.15(257) Operational function sharing supplementary weighting
98.16(257,280) Limited English proficiency (LEP) weighting
98.17(256B,257) Special education weighting
98.18(257) At-risk program, alternative program or alternative school, and potential or returning dropout prevention program formula supplementary weighting
98.19(257) Reorganization incentive weighting
98.20(257) Gifted and talented program
98.21(257) At-risk program, alternative program or alternative school, and potential or returning dropout prevention program—modified supplemental amount
98.22(257) Use of the unexpended general fund balance
98.23(256D,257) Iowa early intervention block grant, also known as early intervention supplement
98.24(257,284) Teacher salary supplement
98.25(257,284) Teacher leadership supplement
98.26(257,284) Educator quality professional development, also known as professional development supplement
98.27 to 98.39 Reserved

DIVISION III
APPROPRIATE USE OF GRANTS IN AID

98.40(256,257,298A) Grants in aid
98.41 Reserved
98.42(257,284) Beginning teacher mentoring and induction program
98.43(257,284A) Beginning administrator mentoring and induction program
98.44(257,301) Nonpublic textbook services
98.45(279) Early literacy
98.46 to 98.59 Reserved

DIVISION IV
APPROPRIATE USE OF SPECIAL TAX LEVIES AND FUNDS

98.60(24,29C,76,143,256,257,274,275,276,279,280,282,283A,285,291,296,298,298A,300,301,423E,423F,565,670) Levies and funds
98.61(24,143,257,275,279,280,285,297,298,298A,301,473,670) General fund
98.62(279,296,298,670) Management fund
98.63(298) Library levy fund
98.64(279,283,297,298) Physical plant and equipment levy (PPEL) fund
98.65(276,300) Public educational and recreational levy (PERL) fund
98.66(257,279,298A,565) District support trust fund
98.67(257,279,298A,565) Permanent funds
98.68(76,274,296,298,298A) Debt service fund
98.69(76,273,298,298A,423E,423F) Capital projects fund
98.70(279,280,298A) Student activity fund
98.71(298A) Entrepreneurial education fund
98.72(256B,257,298A) Special education instruction fund
98.73(282,298A) Juvenile home program instruction fund
98.74(283A,298A) School nutrition fund
98.75(279,298A) Child care and before- and after-school programs fund
98.76(298A) Regular education preschool fund
98.77(298A) Student construction fund
98.78(298A) Other enterprise funds
98.79 to 98.81 Reserved
98.82(298A) Internal service funds
98.83 to 98.91 Reserved
98.92(257,279,298A,565) Private purpose trust funds

98.93(298A) Other trust funds
98.94 to 98.100 Reserved
98.101(298A) Agency funds
98.102 to 98.110 Reserved
98.111(24,29C,257,298A) Emergency levy fund
98.112(275) Equalization levy fund

CHAPTER 99
BUSINESS PROCEDURES AND DEADLINES

99.1(257) Definitions
99.2(256,257,285,291) Submission deadlines
99.3(257) Good cause for late submission
99.4(24,256,257,291) Budgets, accounting and reporting

CHAPTER 100
Reserved

TITLE XVII
PROTECTION OF CHILDREN

CHAPTER 101
Reserved

CHAPTER 102
PROCEDURES FOR CHARGING AND
INVESTIGATING INCIDENTS OF ABUSE
OF STUDENTS BY SCHOOL EMPLOYEES

102.1(280) Statement of intent and purpose
102.2(280) Definitions
102.3(280) Jurisdiction
102.4(280) Exceptions
102.5(280) Duties of school authorities
102.6(280) Filing of a report
102.7(280) Receipt of report
102.8(280) Duties of designated investigator—physical abuse allegations
102.9(280) Duties of designated investigator—sexual abuse allegations
102.10(280) Content of investigative report
102.11(280) Founded reports—designated investigator's duties
102.12(280) Level-two investigator's duties
102.13(280) Retention of records
102.14(280) Substantial compliance
102.15(280) Effective date

CHAPTER 103
CORPORAL PUNISHMENT BAN; RESTRAINT;
PHYSICAL CONFINEMENT AND DETENTION

103.1(256B,280) Purpose
103.2(256B,280) Ban on corporal punishment
103.3(256B,280) Exclusions
103.4(256B,280) Exceptions and privileges
103.5(256B,280) Reasonable force
103.6(256B,280) Physical confinement and detention
103.7(256B,280) Additional minimum mandatory procedures
103.8(256B,280) Additional provisions concerning physical restraint

CHAPTERS 104 to 119
Reserved

TITLE XVIII
EARLY CHILDHOOD

CHAPTER 120
EARLY ACCESS INTEGRATED SYSTEM OF EARLY INTERVENTION SERVICES

DIVISION I
PURPOSE AND APPLICABILITY

120.1(34CFR303) Purposes and outcomes of the Early ACCESS Integrated System of Early Intervention Services
120.2(34CFR303) Applicability of this chapter
120.3(34CFR303) Applicable federal regulations

DIVISION II
DEFINITIONS

120.4(34CFR303) Act
120.5(34CFR303) At-risk infant or toddler
120.6(34CFR303) Child
120.7(34CFR303) Consent
120.8(34CFR303) Council
120.9(34CFR303) Day
120.10(34CFR303) Developmental delay
120.11(34CFR303) Early intervention service program
120.12(34CFR303) Early intervention service provider
120.13(34CFR303) Early intervention services
120.14(34CFR303) Elementary school
120.15(34CFR303) Free appropriate public education
120.16(34CFR303) Health services
120.17(34CFR303) Homeless children
120.18(34CFR303) Include; including
120.19(34CFR303) Indian; Indian tribe
120.20(34CFR303) Individualized family service plan
120.21(34CFR303) Infant or toddler with a disability
120.22(34CFR303) Lead agency
120.23(34CFR303) Local educational agency
120.24(34CFR303) Multidisciplinary
120.25(34CFR303) Native language
120.26(34CFR303) Natural environments
120.27(34CFR303) Parent
120.28(34CFR303) Parent training and information center
120.29(34CFR303) Personally identifiable information
120.30(34CFR303) Public agency
120.31(34CFR303) Qualified personnel
120.32(34CFR303) Scientifically based research
120.33(34CFR303) Secretary
120.34(34CFR303) Service coordination services (case management)
120.35(34CFR303) State
120.36(34CFR303) State educational agency
120.37(34CFR303) Ward of the state
120.38(34CFR303) Other definitions used in this chapter
120.39 to 120.99 Reserved

DIVISION III
STATE ELIGIBILITY FOR A GRANT AND REQUIREMENTS
FOR A STATEWIDE SYSTEM: GENERAL AUTHORITY AND ELIGIBILITY

120.100(34CFR303) General authority
120.101(34CFR303) State eligibility—requirements for a grant under Part C of the Act
120.102(34CFR303) State conformity with Part C of the Act
120.103 and 120.104 Reserved
120.105(34CFR303) Positive efforts to employ and advance qualified individuals with disabilities
120.106 to 120.109 Reserved
120.110(34CFR303) Minimum components of a statewide system
120.111(34CFR303) State definition of developmental delay
120.112(34CFR303) Availability of early intervention services
120.113(34CFR303) Evaluation, assessment, and nondiscriminatory procedures
120.114(34CFR303) Individualized family service plan (IFSP)
120.115(34CFR303) Comprehensive child find system
120.116(34CFR303) Public awareness program
120.117(34CFR303) Central directory
120.118(34CFR303) Comprehensive system of personnel development (CSPD)
120.119(34CFR303) Personnel standards
120.120(34CFR303) Lead agency role in supervision, monitoring, funding, interagency coordination, and other responsibilities
120.121(34CFR303) Policy for contracting or otherwise arranging for services
120.122(34CFR303) Reimbursement procedures
120.123(34CFR303) Procedural safeguards
120.124(34CFR303) Data collection
120.125(34CFR303) State interagency coordinating council
120.126(34CFR303) Early intervention services in natural environments
120.127 to 120.199 Reserved

DIVISION IV
STATE APPLICATION AND ASSURANCES

120.200(34CFR303) State application and assurances
120.201(34CFR303) Designation of lead agency
120.202(34CFR303) Certification regarding financial responsibility
120.203(34CFR303) Statewide system and description of services
120.204 Reserved
120.205(34CFR303) Description of use of funds
120.206(34CFR303) Referral policies for specific children
120.207(34CFR303) Availability of resources
120.208(34CFR303) Public participation policies and procedures
120.209(34CFR303) Transition to preschool and other programs
120.210(34CFR303) Coordination with Head Start and Early Head Start, early education, and child care programs
120.211 Reserved
120.212(34CFR303) Additional information and assurances
120.213 to 120.219 Reserved
120.220(34CFR303) Assurances satisfactory to the Secretary
120.221(34CFR303) Expenditure of funds
120.222(34CFR303) Payor of last resort
120.223(34CFR303) Control of funds and property
120.224(34CFR303) Reports and records
120.225(34CFR303) Prohibition against supplanting; indirect costs
120.226(34CFR303) Fiscal control

120.227(34CFR303) Traditionally underserved groups
120.228(34CFR303) Subsequent state application and modifications of application
120.229 to 120.299 Reserved

DIVISION V
CHILD FIND; EVALUATIONS AND ASSESSMENTS; INDIVIDUALIZED FAMILY SERVICE PLANS

120.300(34CFR303) General
120.301(34CFR303) Public awareness program—information for parents
120.302(34CFR303) Comprehensive child find system
120.303(34CFR303) Referral procedures
120.304 to 120.309 Reserved
120.310(34CFR303) Post-referral timeline (45 calendar days)
120.311 to 120.319 Reserved
120.320(34CFR303) Screening procedures
120.321(34CFR303) Evaluation of the child and assessment of the child and family
120.322(34CFR303) Determination that a child is not eligible
120.323 to 120.339 Reserved
120.340(34CFR303) Individualized family service plan—general
120.341 Reserved
120.342(34CFR303) Procedures for IFSP development, review, and evaluation
120.343(34CFR303) IFSP team meeting and periodic review
120.344(34CFR303) Content of an IFSP
120.345(34CFR303) Interim IFSPs—provision of services before evaluations and assessments are completed
120.346(34CFR303) Responsibility and accountability
120.347 to 120.399 Reserved

DIVISION VI
PROCEDURAL SAFEGUARDS

120.400(34CFR303) General responsibility of lead agency for procedural safeguards
120.401(34CFR303) Confidentiality and opportunity to examine records
120.402(34CFR303) Confidentiality
120.403(34CFR303) Definitions
120.404(34CFR303) Notice to parents
120.405(34CFR303) Access rights
120.406(34CFR303) Record of access
120.407(34CFR303) Records on more than one child
120.408(34CFR303) List of types and locations of information
120.409(34CFR303) Fees for records
120.410(34CFR303) Amendment of records at a parent's request
120.411(34CFR303) Opportunity for a hearing
120.412(34CFR303) Result of hearing
120.413(34CFR303) Hearing procedures
120.414(34CFR303) Consent prior to disclosure or use
120.415(34CFR303) Safeguards
120.416(34CFR303) Destruction of information
120.417(34CFR303) Enforcement
120.418 and 120.419 Reserved
120.420(34CFR303) Parental consent and ability to decline services
120.421(34CFR303) Prior written notice and procedural safeguards notice
120.422(34CFR303) Surrogate parents
120.423 to 120.429 Reserved
120.430(34CFR303) State dispute resolution options
120.431(34CFR303) Mediation

120.432(34CFR303) Adoption of state complaint procedures
120.433(34CFR303) Minimum state complaint procedures
120.434(34CFR303) Filing a complaint
120.435(34CFR303) Appointment of an administrative law judge
120.436(34CFR303) Parental rights in due process hearing proceedings
120.437(34CFR303) Convenience of hearings and timelines
120.438(34CFR303) Civil action
120.439(34CFR303) Limitation of actions
120.440(34CFR303) Rule of construction
120.441(34CFR303) Attorney fees
120.442 to 120.448 Reserved
120.449(34CFR303) State enforcement mechanisms
120.450 to 120.499 Reserved

DIVISION VII
USE OF FUNDS; PAYOR OF LAST RESORT

120.500(34CFR303) Use of funds, payor of last resort, and system of payments
120.501(34CFR303) Permissive use of funds by the department
120.502 to 120.509 Reserved
120.510(34CFR303) Payor of last resort
120.511(34CFR303) Methods to ensure the provision of, and financial responsibility for, Early ACCESS services
120.512 to 120.519 Reserved
120.520(34CFR303) Policies related to use of public benefits or insurance or private insurance to pay for Early ACCESS services
120.521(34CFR303) System of payments and fees
120.522 to 120.599 Reserved

DIVISION VIII
STATE INTERAGENCY COORDINATING COUNCIL

120.600(34CFR303) Establishment of council
120.601(34CFR303) Composition
120.602(34CFR303) Meetings
120.603(34CFR303) Use of funds by the council
120.604(34CFR303) Functions of the council; required duties
120.605(34CFR303) Authorized activities by the council
120.606 to 120.699 Reserved

DIVISION IX
FEDERAL AND STATE MONITORING AND ENFORCEMENT;
REPORTING; AND ALLOCATION OF FUNDS

120.700(34CFR303) State monitoring and enforcement
120.701(34CFR303) State performance plans and data collection
120.702(34CFR303) State use of targets and reporting
120.703(34CFR303) Department review and determination regarding EIS program performance
120.704(34CFR303) Enforcement
120.705(34CFR303) Withholding funds
120.706(34CFR303) Public attention
120.707 Reserved
120.708(34CFR303) State enforcement
120.709(34CFR303) State consideration of other state or federal laws
120.710 to 120.719 Reserved
120.720(34CFR303) Data requirements—general
120.721(34CFR303) Annual report of children served—report requirement
120.722(34CFR303) Data reporting

120.723(34CFR303) Annual report of children served—certification
120.724(34CFR303) Annual report of children served—other responsibilities of the department
120.725 to 120.800 Reserved

DIVISION X
OTHER PROVISIONS

120.801(34CFR303) Early ACCESS system—state level
120.802(34CFR303) Interagency service planning
120.803(34CFR303) System-level disputes
120.804(34CFR303) Early ACCESS system—regional and community levels
120.805(34CFR303) Provision of year-round services
120.806(34CFR303) Evaluation and improvement
120.807(34CFR303) Research
120.808(34CFR303) Records and reports
120.809(34CFR303) Information for department
120.810(34CFR303) Public information
120.811(34CFR303) Dispute resolution: practice before mediators and administrative law judges
120.812(34CFR303) References to federal law
120.813(34CFR303) Severability

CHAPTER 17
OPEN ENROLLMENT

281—17.1(282) Intent and purpose. It is the intent of Iowa Code section 282.18 to maximize parental choice in providing a wide range of educational opportunities which are not available for pupils because of where they live. It is the purpose of this chapter to give guidance and direction to parents/guardians, public school district administrators and boards in making quality decisions regarding school district choice for the education of pupils.

281—17.2(282) Definitions. For the purpose of this chapter the indicated terms are defined as follows:

"Alternative receiving district" means a district to which a parent/guardian petitions for the open enrollment of a pupil from a receiving district. An alternative receiving district could be the district of residence of the parents/guardians.

"Attendance center" means a public school building that contains classrooms used for instructional purposes for elementary, middle, or secondary school students.

"Court-ordered desegregation plan" means a plan that is under direct court order to avoid racial isolation in the district.

"Department" means the department of education.

"Director" means the director of the department of education or the director's designee.

"Diversity plan" or *"voluntary diversity plan"* means a plan that is voluntarily adopted by a local school board to promote diversity and to avoid minority student isolation in the district.

"Eligible district" means a school district whose board had adopted a voluntary desegregation plan under this chapter prior to June 28, 2007.

"Minority student" shall be defined by a local school board in its diversity plan, and may include consideration of any one characteristic or a combination of any of the following characteristics except that race may not be either the sole or the determinative characteristic: socioeconomic status, ethnicity/national origin, English language learner status, or race.

"Open enrollment" is the procedure allowing a parent/guardian to enroll one or more pupils in a public school district other than the district of residence at no tuition cost.

"Receiving district" is the public school district in which a parent/guardian desires to have the pupil enrolled or the district accepting the application for enrollment of a pupil under the provisions of Iowa Code section 282.18.

"Resident district" is the district of residence for school purposes of the parent/guardian and the district in which an open enrollment pupil shall be counted for the purpose of generating state aid regardless of the district in which the pupil is enrolled.

"Sending district" is synonymous with the term resident district.

"Sibling" means a child residing primarily in the same household as the child for whom an open enrollment request is filed and who is related by adoption, blood or marriage to the child for whom an open enrollment request is filed. "Sibling" also includes a foster child who is placed in the same household as the child for whom an open enrollment request is filed.

"Socioeconomic status" means the income level of a student or the student's family, and shall be measured by whether a student or the student's family meets the financial eligibility criteria for free meals or reduced price meals offered under the Child Nutrition Program.

281—17.3(282) Application process. The following procedure shall be used by parents/guardians and school districts in processing open enrollment applications.

17.3(1) *Parent/guardian responsibilities.* On or before March 1 of the school year preceding the school year for which open enrollment is requested, a parent/guardian shall formally notify both the district of residence and the receiving district of the request for open enrollment. The request for open enrollment shall be made on forms provided by the department of education. Failure by the parent to send the form to the resident district and receiving district by the deadline may cause the application to be considered untimely. The parent/guardian is required to indicate on the form if the request is for a pupil

requiring special education, as provided by Iowa Code chapter 256B. The forms for open enrollment application are available from each public school district and area education agency and from the state department of education.

17.3(2) *School district responsibilities.*

a. The board of the resident district shall take no action on an open enrollment request except for a request made under rule 281—17.5(282) or 281—17.14(282).

b. The board of the receiving district shall act on an open enrollment request no later than June 1 of the school year preceding the school year for which the request is made.

(1) The receiving district superintendent shall provide notification of either approval or denial of the request to the parent/guardian and to the resident district within five days of board action.

(2) As an alternative procedure, the receiving board may by policy authorize the superintendent to approve, but not deny, applications filed on or before March 1. The board of directors of a receiving school district may adopt a policy granting the superintendent of the school district authority to approve open enrollment applications submitted after the March 1 deadline, but the board of the receiving district shall take action to approve the request if good cause exists. The board shall have the discretion to determine the scope of the authorization. The authorization may be for regular applications filed on or before March 1, good cause applications, and kindergarten applications filed on or before September 1, or any combination that the board determines. The same timelines for approval, forwarding, and notification shall apply.

c. The parent/guardian may withdraw an open enrollment request anytime prior to the first day of school in the resident district. After the first day of school, an open enrollment request can only be changed during the term of the approval by the procedures of subrules 17.8(4), 17.8(5), 17.8(6), and 17.8(7).

d. The board of the receiving district shall comply with the provisions of rule 281—17.11(282) if the application for open enrollment is for a pupil requiring special education as provided by Iowa Code chapter 256B.

e. Notification to parents.

(1) By September 30 of each school year, all districts shall notify parents of the following:

1. Open enrollment deadlines;

2. Transportation assistance;

3. That within 30 days of a denial of an open enrollment request by a district board of education, the parent/guardian may file an appeal with the state board of education only if the open enrollment request was based on repeated acts of harassment or a serious health condition of the pupil that the district cannot adequately address; and that all other denials must be appealed to the district court in the county in which the primary business office of the district is located; and

4. Possible loss of athletic eligibility for open enrollment pupils.

(2) This notification may be published in a school newsletter, a newspaper of general circulation, a Web site, or a parent handbook provided to all patrons of the district. This information shall also be provided to any parent/guardian of a pupil who enrolls in the district during the school year.

17.3(3) *Exception to process when resident district is under voluntary or court-ordered desegregation.* If the resident district has a voluntary or court-ordered desegregation plan requiring the district to maintain minority and nonminority student ratios, the request for open enrollment shall be filed solely with the district of residence on or before March 1 of the school year preceding the school year for which open enrollment is requested. The superintendent of the resident district may deny a request under this subrule unless the request is made on behalf of a student whose sibling already actively participates in open enrollment to the same receiving district to which open enrollment is sought for this student. A denial by the superintendent may be appealed to the board of the district in which the request was denied. A decision of the local board to uphold the denial may only be appealed to the district court in the county in which is located the primary business office of the district that upheld the denial of the open enrollment request.

[**ARC 2746C**, IAB 10/12/16, effective 11/16/16]

281—17.4(282) Filing after the March 1 deadline—good cause. A parent/guardian may apply for open enrollment after the filing deadline of March 1 of the school year preceding the school year for which open enrollment is requested and before the date specified in Iowa Code section 257.6, subsection 1, of that calendar year if good cause exists for the failure to meet the deadline. Good cause is a change in the status of the pupil's residence or a change in the status of the pupil's resident district taking place after March 1, or the closing or loss of accreditation of a nonpublic school of attendance after March 1 resulting in the desire of the parent/guardian to obtain open enrollment for the following school year. If good cause can be established, the parent/guardian shall be permitted to apply for open enrollment in the same manner as if the deadline had been met pursuant to rule 17.3(282).

Consideration of an open enrollment request filed under the provision of good cause does not preclude the authority, as appropriate, for the resident or receiving district to administer board policy related to insufficient classroom space or the requirements of a desegregation plan or order in acting to approve or deny the request. (See subrules 17.6(2) and 17.6(3).)

17.4(1) Good cause related to change in the pupil's residence shall include:

a. A change in the family residence due to the family's moving from the district of residence anytime after March 1 of the school year preceding the school year for which open enrollment is requested.

b. A change in the state of residence allowing a parent/guardian moving into an Iowa school district from out of state to obtain open enrollment to a different district from their new district of residence.

c. A change in the marital status of the pupil's parents.

d. A guardianship or custody proceeding.

e. Placement of the child in foster care.

f. Adoption.

g. Participation in a foreign exchange program.

h. Participation in a substance abuse or mental health treatment program.

17.4(2) Good cause related to change in status of the pupil's resident district or nonpublic school of attendance shall include:

a. Reorganization action.

(1) Failure of the area education board to vote in favor of a reorganization proposal,

(2) Failure of the area education board to act on objections to exclude territory from a reorganization proposal,

(3) Failure of a reorganization election,

(4) Rescinded IAB 3/8/00, effective 4/12/00.

b. Dissolution action.

(1) Failure of a dissolution commission to make a recommendation to the board of directors,

(2) Failure of the board to take positive action on objections filed by residents of the district to a dissolution proposal,

(3) Failure of contiguous districts to accept a dissolution proposal,

(4) Failure of an election on a dissolution proposal.

c. Whole grade sharing action.

(1) Failure of the board to pursue negotiations for a whole grade sharing proposal for which it has given public notice by board action of its intent to pursue,

(2) Failure of the board to approve a request by a parent/guardian to send an affected pupil to a contiguous district rather than to the district party to the agreement,

(3) Failure of the board to extend or renew a whole grade sharing agreement,

(4) Unilateral rejection by one board of a whole grade sharing agreement prior to expiration of the term of the agreement.

d. Loss of accreditation.

(1) Removal of accreditation by the state board after March 1.

(2) Surrender of accreditation after March 1.

(3) Permanent closure of a nonpublic school after March 1.

e. Rescinded IAB 8/21/02, effective 9/25/02.

On open enrollment requests for good cause related to a change in status of the pupil's school district of residence, action by a parent/guardian must be taken to file notification within 45 days of the last board action or within 30 days of the certification of an election, whichever circumstance is applicable.

17.4(3) Good cause shall not include:

a. Actions of a board of education in the designation of attendance centers within a school corporation and in the assignment of pupils to such centers as provided by Iowa Code section 279.11.

b. Actions of a board of education in making its own rules of government for the internal organization and operation of the school corporation as provided by Iowa Code section 279.8.

17.4(4) Rescinded IAB 8/21/02, effective 9/25/02.

17.4(5) Timelines for board action on applications filed after March 1 for good cause. The board of the receiving district shall act on the request within 30 days of its receipt. The same timelines for approval, forwarding, and notification shall apply.

The receiving district superintendent shall provide notification of either approval or denial of the request to the parent/guardian and to the resident district within five days of board action.

17.4(6) If the resident district believes that the board of the receiving district approved a late-filed open enrollment request that does not meet the definition of "good cause" under Iowa Code section 282.18(4)*"b,"* the resident district may appeal to the director.

a. Upon affirmative vote of a majority of its board to do so, the resident district shall file a written appeal to the director within 30 days of receipt by the resident district of notification by the board of the receiving district of the approval by the receiving district of a late-filed open enrollment request. The written appeal shall state the name and grade level of the affected student, the name of the receiving district, the date of approval by the board of the receiving district, the date the resident district was notified of the approval, and a brief statement explaining why the resident district board believes there is no good cause for the request to have been filed and approved after March 1. The appeal shall be signed by the president of the board of the resident district and shall have attached to it a copy of the disputed open enrollment request and the minutes of the board meeting at which the resident district board voted to appeal. An appeal is timely filed if it is postmarked or delivered personally or via facsimile transmission to the director within the 30-day time period.

b. The director shall, upon receipt of an appeal, first attempt to mediate the dispute. If mediation is unsuccessful, the director shall schedule a telephonic hearing for the purpose of hearing testimony from both boards.

c. If a hearing is necessary, the boards may stipulate to any or all facts to be considered by the director. At the sole discretion of the director, an in-person hearing may be scheduled. The director shall issue a written decision within ten days of the hearing, upholding or reversing the decision of the board of the receiving district.

d. Within five days of the issuance of the decision of the director, the aggrieved board may appeal the decision to the state board of education under the procedures in Iowa Code chapter 290.

281—17.5(282) Filing after the March 1 deadline—harassment or serious health condition. A parent/guardian may apply for open enrollment after the filing deadline of March 1 of the school year preceding the school year for which open enrollment is requested if the parent's/guardian's child is the victim of repeated acts of harassment or if the child has a serious health condition that the resident district cannot adequately address. If either of these conditions exists, the parent/guardian shall be permitted to apply for open enrollment by sending notification to both the resident and receiving districts.

17.5(1) The board of the resident district shall act on the request within 30 days of its receipt. If the request is denied, the parent/guardian shall be notified by the district superintendent within 3 days following board action. If the request is approved, the district superintendent shall forward the approved application form to the receiving district within 5 days following board action and shall notify the parent/guardian within 3 days of this action. The board of the receiving district shall act to approve or deny an open enrollment request within 30 days following receipt of the notice of approval from the

resident district. The receiving district superintendent shall provide notification of either approval or denial of the request to the parent/guardian and to the resident district within 15 days of board action.

17.5(2) A denial by either board of a request made under this rule involving repeated acts of harassment of the student or serious health condition of the student that the resident district cannot adequately address may be appealed by a parent/guardian to the state board of education pursuant to Iowa Code section 290.1. The state board shall exercise broad discretion to achieve just and equitable results that are in the best interest of the affected child or children.

281—17.6(282) Restrictions to open enrollment requests. A district board may exercise the following restrictions related to open enrollment requests.

17.6(1) *Enrollment loss caps.* Rescinded IAB 12/8/93, effective 1/12/94.

17.6(2) *Voluntary diversity plans or court-ordered desegregation plans.* In districts with court-ordered desegregation or voluntary diversity plans where there is a requirement to maintain minority and nonminority student ratios according to the plan, the superintendent of the district may deny a request for open enrollment if it is found that the enrollment or release of a pupil will adversely affect the district's court-ordered desegregation plan or voluntary diversity plan. Open enrollment requests that would facilitate the court-ordered desegregation plan or voluntary diversity plan shall be given priority over other open enrollment requests received by the district. A parent/guardian whose request for open enrollment is denied by the superintendent of the district on the basis of its adverse effect on the district's court-ordered desegregation plan or voluntary diversity plan may appeal that decision to the district board.

17.6(3) *Policy on insufficient classroom space.* No receiving district shall be required to accept an open enrollment request if it has insufficient classroom space to accommodate the pupil(s). Each district board shall adopt a policy which defines the term "insufficient classroom space" for that district. This policy shall establish a basis for the district to make determinations on the acceptance or denial, as a receiving district, of an open enrollment request. This policy may include, but shall not be limited to, one or more of the following: nature of the educational program, grade level, available instructional staff, instructional method, physical space, pupil-teacher ratio, equipment and materials, facilities either being planned or under construction, facilities planned to be closed, finances available, sharing agreement in force or planned, bargaining agreement in force, law or rules governing special education class size, or board-adopted district educational goals and objectives. This policy shall be reviewed annually by the district board.

17.6(4) *Designation of attendance center.* The right of a parent/guardian to request open enrollment is to a district other than the district of residence, not to an attendance center within the nonresident district. In accepting an open enrollment pupil, the receiving district board has the same authority it has in regard to its resident pupils as provided by Iowa Code section 279.11, to "determine the particular school which each child shall attend." In the application process, however, the parent or guardian may request an attendance center of preference.

281—17.7(282) Open enrollment for kindergarten. While the regular time frame in requesting open enrollment is that an application should be made no later than March 1 of the school year preceding the school year for which the enrollment is requested, a parent/guardian requesting to enroll a kindergarten pupil in a district other than the district of residence may make such application on or before September 1 of that school year. In considering an application for a kindergarten pupil, the resident and the receiving district are not precluded from administering board-adopted policies related to insufficient classroom space or the requirements of a desegregation plan or order.

As an alternative procedure, the receiving board may by policy authorize the superintendent to approve, but not deny, applications filed on or before September 1 under this rule. The timelines established in rule 17.4(282) shall apply to applications for a kindergarten pupil.

281—17.8(282) Requirements applicable to parents/guardians and students.

17.8(1) *Expelled or suspended students.* A pupil who has been suspended or expelled by action of the administration or board of the resident district shall not be permitted to enroll if an open enrollment request is filed until the pupil is reinstated for school attendance in the resident district. Once reinstated, the application for open enrollment shall be considered in the same manner as any other open enrollment request. If a pupil for whom an open enrollment request has been filed is subsequently expelled by action of the resident district board, the pupil may be denied enrollment by the receiving district board until the pupil is reinstated for school attendance by the resident district. The provisions of this subrule shall also apply to a pupil who has been suspended or expelled in a receiving district and is requesting open enrollment to an alternative receiving district or is seeking to return to the resident district as outlined in subrule 17.8(4).

17.8(2) *Restrictions on participation in interscholastic athletic contests and competitions.* A pupil who changes school districts under open enrollment in any of the grades 9 through 12 shall not be eligible to participate in varsity interscholastic athletic contests and competitions during the first 90 school days of enrollment. This restriction also shall apply to enrollments resulting from an approved petition filed by a parent/guardian to open enroll to an alternative receiving district and when the pupil returns to the district of residence using the process outlined in subrule 17.8(4). This 90-school-day restriction does not prohibit the pupil from practicing with an athletic team during the 90 school days of ineligibility. This 90-school-day restriction is not applicable to a pupil who:

a. Participates in an athletic activity in the receiving district that is not available in the district of residence.

b. Participates in an athletic activity for which the resident district and the receiving district have a "cooperative student participation agreement" in place as provided by rule 281—36.20(280).

c. Has paid tuition for one or more years to the receiving school district prior to making application and being approved for open enrollment.

d. Has attended the receiving district for one or more years, prior to making application and being approved for open enrollment, under a sharing or mutual agreement between the resident district and the receiving district.

e. Has been participating in open enrollment and whose parents/guardians move out of their district of residence but exercise the option of maintaining the open enrollment agreement as provided in subrule 17.8(6) except that the period of 90 school days of ineligibility shall apply to a pupil who open enrolls to another school district. If the pupil has established athletic eligibility under open enrollment, it is continued despite the parent's or guardian's change in residence.

f. Obtains open enrollment as provided in subrule 17.8(7) except that the period of 90 school days of ineligibility shall apply to a pupil who open enrolls to another school district.

g. Obtains open enrollment due to the dissolution and merger of the former district of residence under Iowa Code subsection 256.11(12).

h. Obtains open enrollment due to the pupil's district of residence entering into a whole-grade sharing agreement on or after July 1, 1990, including the grade in which the pupil would be enrolled at the start of the whole-grade sharing agreement.

i. Participates in open enrollment and the parent/guardian is an active member of the armed forces and resides in permanent housing on government property provided by a branch of the armed services.

j. Open enrolls from a district of residence that has determined that the pupil was previously subject to a founded incident of harassment or bullying as defined in Iowa Code section 280.28 while attending school in the district of residence.

17.8(3) *Term of enrollment.* Rescinded IAB 10/9/96, effective 11/13/96.

17.8(4) *Petition for attendance in an alternative receiving district.* Once the pupil of a parent/guardian has been accepted for open enrollment, attendance in an alternative receiving district under open enrollment can be initiated by filing a petition for change with the receiving district. The petition shall be filed by the parent/guardian with the receiving district on or before March 1 of the year preceding the school year for which the change is requested. The timelines and notification requirements for such a request shall be the same as outlined in subrule 17.3(2). If the request is

approved, the alternative district shall send notice of this action to the parent/guardian, to the original receiving district, and to the resident district of the pupil. Petitions for change shall be effectuated at the start of the next school year.

As an alternative procedure, the receiving and alternative receiving district boards by mutual agreement may effectuate the change in enrollment of an open enrollment pupil at any time following receipt of a written request for such change which is approved by the two boards. The parent/guardian and the resident district board shall be notified of the approval and the date for change in open enrollment within 15 days of the mutual agreement action of the receiving and alternative receiving boards.

A pupil in good standing may return to the district of residence at any time following written notice from the parent/guardian to both the resident district and the receiving district.

17.8(5) *Renewal of an open enrollment agreement.* An open enrollment agreement shall remain in place unless canceled by the parent/guardian or terminated as outlined in the provisions of subrule 17.8(10).

17.8(6) *Change in residence when participating in open enrollment.* If the parent/guardian of a pupil who is participating in open enrollment changes the school district of residence during the term of the agreement, the parent/guardian shall have the option to leave the pupil in the receiving district under open enrollment, to open enroll to another school district, or to enroll the pupil in the new district of residence, thus terminating the open enrollment agreement. If the choice is to leave the pupil under open enrollment or to open enroll to another school district, the original district of residence shall be responsible for payment of the cost per pupil plus any applicable weightings or special education costs for the balance of the school year, if any, in which the move took place, providing the move took place on or after the date specified in Iowa Code section 257.6, subsection 1. The new district of residence shall be responsible for these payments during succeeding years of the agreement.

If the move takes place between the end of one school year and the date specified in Iowa Code section 257.6, subsection 1, of the following school year, the new district of residence shall be responsible for that year's payment as well as succeeding years.

If the pupil is to remain under open enrollment or to open enroll to another school district, the parent/guardian shall write a letter, delivered by mail or by hand on or before the date specified in Iowa Code section 257.6, subsection 1, to notify the original resident district, the new resident district, and the receiving district of this decision.

Timely requests under this rule shall not be denied. If the request is for a high school pupil, the pupil shall not be subject to the initial 90-school-day ineligibility period of subrule 17.8(2).

17.8(7) *Change in residence when not participating in open enrollment.* If a parent/guardian moves out of the school district of residence, and the pupil is not currently under open enrollment, the parent/guardian has the option for the pupil to remain in the original district of residence as an open enrollment pupil with no interruption in the education program or to open enroll to another school district. This option is not available to the parent/guardian of a student who is entering kindergarten for the first time. The parent/guardian exercising this option shall file an open enrollment request form with the new district of residence for processing and record purposes. This request shall be made on or before the date specified in Iowa Code section 257.6, subsection 1. Timely requests under this subrule shall not be denied. If the request is for a high school pupil, the pupil shall not be subject to the initial 90-school-day ineligibility period of subrule 17.8(2). If the move is on or after the date specified in Iowa Code section 257.6, subsection 1, the new district of residence is not required to pay per-pupil costs or applicable weighting or special education costs to the receiving district until the first full year of the open enrollment.

17.8(8) *Pupil governance.* An open enrollment pupil, and where applicable the pupil's parent/guardian, shall be governed by the rules and policies established by the board of directors of the receiving district. Any complaint or appeal by the parent/guardian concerning the educational system, its process, or administration in the receiving district shall be initially directed to the board of directors of that district in compliance with the policy of that district.

17.8(9) *Appeal procedure.* A parent/guardian may appeal the decision of the board of directors of a school district (resident or receiving) only on an application for open enrollment under Iowa Code

section 282.18(5) as amended by 2002 Iowa Acts, House File 2515. This appeal is to the state board of education and shall comply with the provisions of Iowa Code section 290.1. The appeal shall be filed within 30 days of the decision of the district board and shall be in the form of an affidavit signed by the parent/guardian. It shall state in a plain and concise manner what the parent/guardian feels to be the basis for appeal.

17.8(10) *Open enrollment termination.* Open enrollment ends when:

a. The pupil graduates, moves into the receiving district, moves into a third district and does not elect to continue attending in the receiving district, moves out of state, elects to attend a nonpublic school instead of the receiving district, or any other circumstance not excepted below that results in the pupil no longer attending the receiving district.

EXCEPTIONS: This rule shall not apply if the pupil is placed temporarily in foster care, a juvenile detention center, mental health or substance abuse treatment facility, or other similar placement. In such cases, the open enrollment status will automatically be reinstated when the pupil returns.

b. The pupil drops out of school. In this instance, if the pupil desires to return to the resident district during the term of the original open enrollment, notice must be given as outlined in the provisions of subrule 17.8(4).

[**ARC 2746C**, IAB 10/12/16, effective 11/16/16]

281—17.9(282) Transportation.

17.9(1) *Parent responsibilities.* The parent/guardian of a pupil who has been accepted for open enrollment shall be responsible to transport the pupil without reimbursement, except as provided in subrule 17.9(2), to and from a point on a regular school bus route of the receiving district. This point shall be a designated stop on the bus route of the receiving district. If this point—designated stop— is within the distances established by Iowa Code section 285.1 from the school designated for attendance by the receiving district, that district may, but is not required to, provide transportation for an open enrollment pupil. A receiving district may send buses into a resident district solely for the purpose of transporting an open enrollment pupil if the boards of both the sending and receiving districts agree to this arrangement. Bus routes that are outside the boundary of the receiving district that have been authorized by an area education agency board of directors, as provided by Iowa Code subsection 285.9(3), may be used to transport open enrollment pupils if boards of directors of the resident and receiving districts have both taken action to approve such an arrangement. Bus routes that have been established by the receiving district for the purpose of transporting nonpublic school or special education pupils that operate in the resident district of an open enrollment pupil shall not be utilized for the transportation of such pupil for the portion of the route that is within the resident district unless the boards of directors of the resident and receiving districts have both taken action to approve such an arrangement. Bus routes transporting pupils for the purpose of whole-grade sharing shall not be used to transport open enrollment pupils for the portion of the route that is within the resident district unless the boards of directors of the resident and receiving districts have both taken action to approve such an arrangement.

17.9(2) *Qualifications and provisions for transportation assistance.* Open enrollment pupils that meet the economic eligibility requirements established by the department of education shall receive transportation assistance from their resident district under the following conditions. The resident district is not required to provide any transportation assistance for a pupil involved in open enrollment with a district that is not contiguous with the pupil's resident district. The resident district shall provide transportation for the pupil to a point that is a designated stop on a regular bus route of a contiguous receiving district, or as an alternative, the resident district shall pay the parent/guardian for providing this transportation. In either situation the resident district is not obligated to expend more than the average cost per pupil transported amount established for that district for the previous school year. If the resident district provides the transportation, it shall determine that it is able to perform this function at a cost not in excess of the average cost per pupil transported for the resident district as established the previous year. It shall not assess any additional cost to the parent/guardian for providing transportation. If the district chooses to reimburse the parent/guardian for providing transportation, to determine the amount to be

reimbursed, the district shall use the provisions of Iowa Code subsection 285.1(3). This reimbursement shall not exceed the average cost per pupil transported for the resident district as established the previous year. The resident district may withhold from the amount it is required to pay to a receiving district for an open enrollment pupil the actual amount or the average cost per pupil transported amount it pays for transportation assistance, whichever is the lesser amount.

17.9(3) *Economic eligibility requirements for transportation.* A parent/guardian shall be eligible for transportation assistance from the resident district if the household income of the parent/guardian is at or below 160 percent of the federal income poverty guidelines as stated by household size. Since the federal income poverty guidelines are adjusted each year, the department of education shall provide revised eligibility guidelines to school districts each year.

281—17.10(282) Method of finance. Open enrollment options shall be made available for pupils at no instructional cost to their parents/guardians. Open enrollment pupils shall be considered enrolled resident pupils in the resident district and shall be included in the certified enrollment count of that district for the purposes of generating school foundation aid.

17.10(1) *Full-time pupils.* Unless otherwise agreed to in the mediation under paragraph 17.4(6)*"b,"* for full-time pupils, the resident district shall pay each year to the receiving district an amount equal to the sum of the state cost per pupil for the previous year; plus any moneys received for the pupil as a result of non-English speaking weighting provided by Iowa Code section 280.4; plus either the teacher leadership supplement state cost per pupil for the previous year as provided in Iowa Code section 257.9(11) or the teacher leadership supplement foundation aid allocation for fiscal year 2017 as provided in Iowa Code section 284.13(1)*"e,"* whichever the district received, if both the district of residence and the receiving district received either of the supplements. If the pupil participating in open enrollment is also an eligible pupil under Iowa Code section 261E.6 (postsecondary enrollment options program), the receiving district shall pay the tuition reimbursement amount to an eligible postsecondary institution as provided in Iowa Code section 261E.7.

17.10(2) *Dual enrolled pupils.* Unless otherwise agreed to in the mediation under paragraph 17.4(6)*"b,"* for pupils who receive competent private instruction and are dual enrolled, the resident district shall pay each year to the receiving district an amount equal to .1 times the state cost per pupil for the previous year plus any moneys received for the pupil as a result of non-English speaking weighting provided by Iowa Code section 280.4. However, a pupil dual enrolled in grades nine through twelve shall be counted by the receiving district in the same manner as a shared-time pupil under Iowa Code section 257.6(1)*"c."*

17.10(3) *Home school assistance program pupils.* Unless otherwise agreed to in the mediation under paragraph 17.4(6)*"b,"* for pupils who receive competent private instruction and are registered for a home school assistance program, the resident district shall pay each year to the receiving district an amount equal to .3 times the state cost per pupil under Iowa Code chapter 257 for the previous year plus any moneys received for the pupil as a result of non-English speaking weighting provided by Iowa Code section 280.4.

17.10(4) *Transportation assistance.* The resident district may deduct any transportation assistance funds for which the pupil is eligible as provided by subrule 17.9(2).

17.10(5) *Method of payment.* These moneys shall be paid to the receiving district by the first resident district according to the timeline in Iowa Code section 282.20(3) (on or before February 15 and July 15 of each year). Payments shall be made to the receiving district in a timely manner. The district cost per pupil for nonspecial education students shall be the cost calculated each year for the school year preceding the school year for which the open enrollment takes place. Costs for special education students shall be as outlined in rule 281—17.11(282).

17.10(6) *Partial-year situations.* In the event that the pupil who is under open enrollment withdraws from school, moves into the district of attendance, moves out of state, moves to another district in the state of Iowa and elects to attend that district, graduates at midyear, is allowed to return to the district of residence during the school year, or other similar set of circumstances that result in the pupil no longer attending in the receiving district, payment of cost per pupil will be prorated.

17.10(7) *Late changes of open enrollment.* The resident district and the receiving district boards by mutual agreement may effectuate the change in enrollment of an open enrollment pupil at any time following receipt of a petition for such change which is approved by the two boards. A change due to good cause is a late change in enrollment. If any change in enrollment is made on or after the date specified in Iowa Code section 257.6, subsection 1, the resident district is not required to pay per-pupil costs or applicable weighting or special education costs to the receiving district until the first full year of the open enrollment.

17.10(8) A student under open enrollment is eligible to be counted for supplementary weighting pursuant to 281—subrule 97.2(5) for qualifying concurrent enrollment classes in which the student is enrolled, including concurrent enrollment classes provided via the ICN, or supplementary weighting for project lead the way (PLTW) enrollment through sharing with a community college pursuant to 281—subrule 97.2(6). An open enrolled student who is under competent private instruction (CPI) shall be weighted in the student's receiving district, and no tuition shall be billed to the resident district. An open enrolled student who is not under CPI shall be weighted in the resident district, and the funding shall be sent to the receiving district in addition to open enrollment tuition.

a. If the open enrolled student is present in the resident district on October 1 of the school year, the resident district shall count the student, excluding a student under CPI, for supplementary weighting.

b. The concurrent enrollment course must qualify for supplementary weighting in the receiving district pursuant to 281—subrule 97.2(5), and the PLTW course must qualify for supplementary weighting in the receiving district pursuant to 281—subrule 97.2(6).

c. The resident district shall forward the weighting generated for the concurrent or PLTW enrollment for that student using the district cost per pupil of the school year. The amount generated is calculated as the supplementary weighting full-time-equivalency for that one student for each qualified concurrent or PLTW enrollment course multiplied by the current school year's district cost per pupil in the resident district.

d. The receiving district shall pay the community college the tuition negotiated for the course. The tuition negotiated may cost the receiving district a different amount than that received from the resident district. No additional amount may be charged to the resident district, the student, or the parent, guardian, or legal custodian.

e. If the student was not present in the resident district on October 1 of the school year and is a late transfer, the receiving district bears all the tuition cost and shall not bill the resident district in the first year pursuant to subrule 17.10(7).

[**ARC 9261B**, IAB 12/15/10, effective 1/19/11; **ARC 0521C**, IAB 12/12/12, effective 1/16/13; **ARC 2746C**, IAB 10/12/16, effective 11/16/16; **ARC 3181C**, IAB 7/5/17, effective 8/9/17]

281—17.11(282) Special education students. If a parent/guardian requests open enrollment for a pupil requiring special education, as provided by Iowa Code chapter 256B, this request shall receive consideration under the following conditions. The request shall be granted only if the receiving district is able to provide within that district the appropriate special education program for that student in accordance with Iowa rules of special education, 281—Chapter 41. This determination shall be made by the receiving district in consultation with the resident district and the appropriate area education agency(ies) before approval of the application. In a situation where the appropriateness of the program is in question, the pupil shall remain enrolled in the program of the resident district until a final determination is made. If the appropriateness of the special education program in the resident district is questioned by the parent, then the parent may request a due process hearing as provided by 281—41.507(256B,34CFR300) or a mediation conference as provided by 281—41.506(256B,34CFR300). If the appropriateness of the special education program in the receiving district is at issue, the final determination of the appropriateness of a special education instructional program shall be the responsibility of the director of special education of the area education agency in which the receiving district is located, based upon the decision of the child's individualized education program team, which shall include a representative from the resident district that has the authority to commit district resources, and which decision is subject to the parent's procedural safeguards.

District transportation requirements, parent/guardian responsibilities and, where applicable, financial assistance for an open enrollment special education pupil shall be as provided by rule 281—17.9(282).

The district of residence shall pay to the receiving district on the schedule set forth in subrule 17.10(5) the actual costs incurred by the receiving district in providing the appropriate special education program. These costs shall be based on the current year expenditures with needed adjustments made in the final payment. The responsibility for ensuring that an appropriate program is maintained for an open enrollment special education pupil shall rest with the resident district. The receiving district and the receiving area education agency director shall provide, at least on an annual basis, evaluation reports and information to the resident district on each special education open enrollment pupil. The receiving district shall provide notice to the resident district of all staffings scheduled for each open enrollment pupil. For an open enrolled special education pupil where the receiving district is located in an area education agency other than the area education agency within which the resident district is located, the resident district and the receiving district are required to forward a copy of any approved open enrollment request to the director of special education of their respective area education agencies. Any moneys received by the area education agency of the resident district for an approved open enrollment special education pupil shall be forwarded to the receiving district's area education agency.
[**ARC 3181C**, IAB 7/5/17, effective 8/9/17]

281—17.12(282) Laboratory school provisions. Rescinded **ARC 2746C**, IAB 10/12/16, effective 11/16/16.

281—17.13(282) Applicability. For implementing the open enrollment provisions of Iowa Code section 282.18, the provisions of this chapter shall be retroactively applicable to June 5, 1989.

281—17.14(282) Voluntary diversity plans or court-ordered desegregation plans.

17.14(1) *Applicability.* These rules govern only the components of a voluntary diversity plan or court-ordered desegregation plan as the plan affects open enrollments. Nothing herein shall prohibit a district from implementing a lawful voluntary diversity plan or court-ordered desegregation plan or components thereof for transfers other than open enrollment.

17.14(2) *Eligibility to adopt and implement a plan applicable to open enrollments.*

a. Adoption. The board of an eligible school district may adopt a voluntary diversity plan with a component that applies to open enrollments if either of the following conditions exists: (1) The percentage of minority students in the district exceeds the percentage of minority students in the state by at least 20 percentage points; or (2) the percentage of minority students in one or more attendance centers in the district exceeds the percentage of minority students in the district as a whole by at least 20 percentage points.

b. Implementation. The open enrollment component of the plan adopted by the district board shall only be implemented by the district if other components of the diversity plan describe the steps the district is taking internally to avoid or reduce minority student isolation, and the district demonstrates the extent to which it has implemented those steps. For districts with multiple attendance centers at the same grade level, such steps may include intradistrict student transfer policies, pairing of attendance centers, revision of boundaries of attendance centers, selecting school sites, realignment of feeder systems, magnet schools, and the placement of specialized programs and services. In a district without multiple attendance centers at the same grade level, such steps may include pupil assignments to classrooms, classroom pairing, community and family outreach programs, student-to-student mentoring or grouping designed to promote understanding and acceptance of and positive interactions with all groups of minority students, and professional development activities designed to promote understanding and acceptance of and positive interactions with all groups of minority students. The open enrollment component of the plan adopted by the district board may remain in effect for so long as the district's

total minority student population exceeds 15 percent, and shall remain in effect for so long as the district demonstrates is necessary to avoid minority student isolation in the district.

17.14(3) *Open enrollment elements of a diversity plan.*

a. All applicable deadlines for the filing and determination of open enrollment requests, including the exceptions for good cause under rule 17.4(282), apply to open enrollment requests filed in a district that has adopted an open enrollment component in its voluntary diversity plan.

b. The plan shall establish a districtwide ratio of minority-to-nonminority students to be maintained, consistent with subrule 17.14(2). All open enrollment requests, both those into and out of the district, shall be acted on according to whether the request will adversely affect or will positively affect the implementation of the plan. Under Iowa Code section 282.18, if an open enrollment request would positively affect the plan, the district shall give priority to granting the request over other requests.

c. A district with multiple attendance centers at the same grade level shall specify in the open enrollment component of its diversity plan which attendance centers are affected by the open enrollment component. For each of those attendance centers, the district shall establish and specify the individual attendance center ratios of minority-to-nonminority students, consistent with subrule 17.14(2). The plan may provide for an initial determination of whether a requested open enrollment will negatively affect the specific attendance center ratio. With respect to a request to open enroll out of the district, if such enrollment will negatively affect the ratio established for the student's current attendance center, the request may be denied by the district with no further determination of the impact of the request on the districtwide ratio. For a request to open enroll either into or out of the district, if the open enrollment will not negatively affect the attendance center ratio, the request shall be denied only if there would be a negative impact on the districtwide ratio. As of July 1, 2003, if a district's plan sets a threshold lower than allowed in paragraph 17.14(2)*"a"* and that plan has not been disapproved by a court of competent jurisdiction, the district may implement its individual attendance center ratios in addition to its districtwide ratio.

d. The plan shall include provision for the formation and operation of a waiting list for those requests that could not be granted immediately. A parent/guardian of a child on the waiting list must be informed by the district of the details of the operation of the list and whether the parent/guardian must refile a timely request for open enrollment in order to remain on the waiting list.

e. The plan shall specify a district contact person to whom questions may be directed from parents/guardians.

f. The plan shall include a provision whereby a parent/guardian has a means to request that the district determine whether a hardship exists for granting a request that may not otherwise be granted under the plan.

17.14(4) *Exceptions.* The following exceptions shall apply:

a. If an open enrollment request is filed on behalf of a student whose sibling is already participating in open enrollment to the same district to which the student desires open enrollment, the request shall be granted.

b. If an open enrollment request is filed on behalf of a student whose parent/guardian moves out of the school district of residence and who wishes to remain in the district of residence as an open enrolled student without interruption in the student's educational program under subrule 17.8(7), the request shall be granted. This option is not available to the parent/guardian of a student who is entering kindergarten for the first time.

c. A request for open enrollment based on repeated acts of harassment of the student shall not be denied on the basis that such request would have an adverse impact on the district's ratio of minority-to-nonminority students.

d. A request for open enrollment based on a serious health condition of the student that the district cannot adequately address shall not be denied on the basis that such request would have an adverse impact on the district's ratio of minority-to-nonminority students.

17.14(5) *Review by department.* All voluntary desegregation plans adopted under this rule prior to June 28, 2007, are no longer valid. An eligible district whose board desires to adopt a voluntary diversity plan for open enrollment must do so by March 1, 2008. The district shall submit a copy of its plan to the

department for review within 10 days of the adoption of the plan. Open enrollment requests received prior to March 1, 2008, by a district that has a voluntary diversity plan may be held by the district for action pursuant to the district's new voluntary diversity plan.

The department shall inform the district within 10 days of receipt of the district's voluntary diversity plan whether the plan complies with this rule. All changes to voluntary diversity plans for open enrollment shall be submitted to the department within 60 days of local board action.

These rules are intended to implement Iowa Code Supplement section 282.18.

[Filed emergency 7/7/89—published 7/26/89, effective 7/7/89]
[Filed 2/2/90, Notices 7/26/89, 8/9/89—published 2/21/90, effective 3/28/90]
[Filed emergency 5/25/90—published 6/13/90, effective 5/25/90]
[Filed 9/28/90, Notice 6/13/90—published 10/17/90, effective 11/21/90]
[Filed 11/22/91, Notice 10/2/91—published 12/11/91, effective 1/15/92]
[Filed 8/26/92, Notice 6/24/92—published 9/16/92, effective 10/21/92]
[Filed 11/19/93, Notice 9/29/93—published 12/8/93, effective 1/12/94]
[Filed 11/17/94, Notice 9/28/94—published 12/7/94, effective 1/11/95]
[Filed 11/21/95, Notice 9/13/95—published 12/20/95, effective 1/24/96]
[Filed 9/13/96, Notice 7/17/96—published 10/9/96, effective 11/13/96]
[Filed 3/20/98, Notice 2/11/98—published 4/8/98, effective 5/13/98]
[Filed 2/11/00, Notice 12/15/99—published 3/8/00, effective 4/12/00]
[Filed emergency 8/4/00—published 8/23/00, effective 8/7/00]
[Filed 4/19/02, Notice 2/6/02—published 5/15/02, effective 6/19/02]
[Filed 8/2/02, Notice 6/26/02—published 8/21/02, effective 9/25/02]
[Filed emergency 11/21/02—published 12/11/02, effective 11/21/02]
[Filed 1/17/03, Notice 12/11/02—published 2/5/03, effective 3/12/03]
[Filed 6/17/04, Notice 5/12/04—published 7/7/04, effective 8/11/04]
[Filed 11/15/06, Notice 10/11/06—published 12/6/06, effective 1/10/07]
[Filed 7/27/07, Notice 5/9/07—published 8/15/07, effective 9/19/07]
[Filed 2/8/08, Notice 12/19/07—published 2/27/08, effective 4/2/08]
[Filed 11/20/08, Notice 8/27/08—published 12/17/08, effective 1/21/09]
[Filed ARC 9261B (Notice ARC 9143B, IAB 10/6/10), IAB 12/15/10, effective 1/19/11]
[Filed ARC 0521C (Notice ARC 0384C, IAB 10/3/12), IAB 12/12/12, effective 1/16/13]
[Filed ARC 2746C (Notice ARC 2609C, IAB 7/6/16), IAB 10/12/16, effective 11/16/16]
[Filed ARC 3181C (Notice ARC 3031C, IAB 4/26/17), IAB 7/5/17, effective 8/9/17]

CHAPTER 85
CLASSIFICATION OF CERTIFICATES (Through 9/30/88)
[Prior to 9/7/88, see Public Instruction Department[670] Ch 14]
Rescinded 11/14/90, see IAB 12/12/90

CHAPTER 86
ENDORSEMENTS (Through 9/30/88)
[Prior to 9/7/88, see Public Instruction Department[670] Ch 15]
Rescinded 11/14/90, see IAB 12/12/90

CHAPTER 87
APPROVALS (Through 9/30/88)
[Prior to 9/7/88, see Public Instruction Department[670] Ch 16]
Rescinded 11/14/90, see IAB 12/12/90

CHAPTER 88
CONVERSION AND RENEWAL OF CERTIFICATES (Through 9/30/88)
[Prior to 9/7/88, see Public Instruction Department[670] Ch 17]
Rescinded 11/14/90, see IAB 12/12/90

CHAPTER 89
STANDARDS FOR TEACHER EDUCATION PROGRAMS (Through 9/30/88)
[Prior to 9/7/88, see Public Instruction Department[670] Ch 19]
Rescinded 11/14/90, see IAB 12/12/90

CHAPTER 90
STANDARDS FOR GRADUATE TEACHER EDUCATION PROGRAMS
[Prior to 9/7/88, see Public Instruction Department[670] Ch 20]
Rescinded IAB 12/16/98, effective 1/20/99

CHAPTER 91
PHASE III, EDUCATIONAL EXCELLENCE PROGRAM
[Prior to 9/7/88, see Public Instruction Department[670] Ch 80]
Rescinded IAB 5/20/09, effective 6/24/09

CHAPTERS 92 and 93
Reserved

TITLE XV
EDUCATIONAL EXCELLENCE

CHAPTER 94
ADMINISTRATIVE ADVANCEMENT AND RECRUITMENT PROGRAM
Rescinded **ARC 3180C**, IAB 7/5/17, effective 8/9/17

EDUCATIONAL EXAMINERS BOARD[282]

[Prior to 6/15/88, see Professional Teaching Practices Commission[640]]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287]]

CHAPTER 1
GENERAL

1.1(272) Definition
1.2(272,17A) Organization and method of operation

CHAPTER 2
PETITIONS FOR RULE MAKING
(Uniform Rules)

2.1(17A) Petition for rule making
2.3(17A) Inquiries

CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)

3.1(17A) Petition for declaratory order
3.2(17A) Notice of petition
3.3(17A) Intervention
3.5(17A) Inquiries

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

4.3(17A) Public rule-making docket
4.4(17A) Notice of proposed rule making
4.5(17A) Public participation
4.6(17A) Regulatory analysis
4.11(17A) Concise statement of reasons
4.13(17A) Agency rule-making record

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

5.1(22,272) Definitions
5.3(22,272) Request for access to records
5.6(22,272) Procedure by which additions, dissents, or objections may be entered into certain records
5.9(22,272) Disclosures without the consent of the subject
5.10(22,272) Routine use
5.11(272) Consensual disclosure of confidential records
5.12(272) Release to subject
5.13(272) Availability of records
5.14(272) Personally identifiable information
5.15(272) Other groups of records
5.16(272) Applicability

CHAPTER 6
WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

6.1(17A) Definition
6.2(17A) Scope of chapter
6.3(17A) Applicability of chapter

6.4(17A) Criteria for waiver or variance
6.5(17A) Filing of petition
6.6(17A) Content of petition
6.7(17A) Additional information
6.8(17A) Notice
6.9(17A) Hearing procedures
6.10(17A) Ruling
6.11(17A) Public availability
6.12(17A) Summary reports
6.13(17A) Cancellation of a waiver
6.14(17A) Violations
6.15(17A) Defense
6.16(17A) Judicial review

CHAPTER 7
PROOF OF LEGAL PRESENCE

7.1(272) Purpose
7.2(272) Applicability
7.3(272) Acceptable evidence

CHAPTER 8
DEBTS TO STATE OR LOCAL GOVERNMENT—NONCOMPLIANCE

8.1(272D) Issuance or renewal of a license—denial
8.2(272D) Suspension or revocation of a license
8.3(17A,22,272D) Sharing of information

CHAPTER 9
STUDENT LOAN DEFAULT/NONCOMPLIANCE
WITH AGREEMENT FOR PAYMENT OF OBLIGATION

9.1(261) Issuance or renewal of a license—denial
9.2(261) Suspension or revocation of a license
9.3(17A,22,261) Sharing of information

CHAPTER 10
CHILD SUPPORT NONCOMPLIANCE

10.1(272,252J) Issuance or renewal of a license—denial
10.2(252J) Suspension or revocation of a license
10.3(17A,22,252J) Sharing of information

CHAPTER 11
COMPLAINTS, INVESTIGATIONS,
CONTESTED CASE HEARINGS

11.1(17A,272) Scope and applicability
11.2(17A) Definitions
11.3(17A,272) Jurisdictional requirements
11.4(17A,272) Complaint
11.5(272) Investigation of complaints or license reports
11.6(272) Ruling on the initial inquiry
11.7(17A,272) Notice of hearing
11.8(17A,272) Presiding officer
11.9(17A,272) Waiver of procedures
11.10(17A,272) Telephone proceedings
11.11(17A,272) Disqualification

11.12(17A,272) Consolidation—severance
11.13(17A,272) Pleadings
11.14(17A,272) Service and filing of pleadings and other papers
11.15(17A,272) Discovery
11.16(17A,272) Subpoenas
11.17(17A,272) Motions
11.18(17A,272) Prehearing conference
11.19(17A,272) Continuances
11.20(17A,272) Intervention
11.21(17A,272) Hearing procedures
11.22(17A,272) Evidence
11.23(17A,272) Default
11.24(17A,272) Ex parte communication
11.25(17A,272) Recording costs
11.26(17A,272) Interlocutory appeals
11.27(17A,272) Final decision
11.28(17A,272) Appeals and review
11.29(17A,272) Applications for rehearing
11.30(17A,272) Stays of board actions
11.31(17A,272) No factual dispute contested cases
11.32(17A,272) Emergency adjudicative proceedings
11.33(272) Methods of discipline
11.34(272) Reinstatement
11.35(272) Application denial and appeal
11.36(272) Denial of renewal application
11.37(272) Mandatory reporting of contract nonrenewal or termination or resignation based on allegations of misconduct
11.38(256,272) Reporting by department of education employees
11.39(272) Denial of application during a pending professional practices case

CHAPTER 12
FEES

12.1(272) Issuance of licenses, certificates, authorizations, and statements of professional recognition
12.2(272) Fees for the renewal or extension of licenses, certificates, statements of professional recognition, and authorizations
12.3(272) Evaluation fee
12.4(272) Adding endorsements
12.5(272) Duplicate licenses, authorizations, and statements of professional recognition
12.6(272) Late fees
12.7(272) Fees nonrefundable
12.8(272) Portfolio review and evaluation fee
12.9(272) Retention of incomplete applications

CHAPTER 13
ISSUANCE OF TEACHER LICENSES AND ENDORSEMENTS

13.1(272) All applicants desiring Iowa licensure
13.2 to 13.4 Reserved
13.5(272) Teacher licenses
13.6(272) Specific requirements for an initial license
13.7(272) Specific requirements for a standard license
13.8(272) Specific requirements for a master educator's license

13.9(272) Teacher intern license
13.10(272) Specific requirements for a Class A extension license
13.11(272) Specific requirements for a Class B license
13.12 and 13.13 Reserved
13.14(272) Specific requirements for a Class E emergency extension license
13.15(272) Specific requirements for a Class G license
13.16(272) Specific requirements for a substitute teacher's license
13.17(272) Specific requirements for exchange licenses
13.18 to 13.25 Reserved
13.26(272) Requirements for elementary endorsements
13.27(272) Requirements for middle school endorsements
13.28(272) Minimum content requirements for teaching endorsements
13.29(272) Adding, removing or reinstating a teaching endorsement
13.30(272) Licenses—issue dates, corrections, duplicates, and fraud

CHAPTER 14
SPECIAL EDUCATION ENDORSEMENTS
14.1(272) Special education teaching endorsements
14.2(272) Specific requirements

CHAPTER 15
SPECIAL EDUCATION SUPPORT PERSONNEL AUTHORIZATIONS
15.1(272) Authorizations requiring a license
15.2(272) Special education consultant
15.3(272) Itinerant hospital services or home services teacher
15.4(272) Special education media specialist
15.5(272) Supervisor of special education—instructional
15.6(272) Work experience coordinator
15.7(272) Other special education practitioner endorsements

CHAPTER 16
STATEMENTS OF PROFESSIONAL RECOGNITION (SPR)
16.1(272) Statement of professional recognition (SPR)
16.2(272) School audiologist
16.3(272) School nurse
16.4(272) School occupational therapist
16.5(272) School physical therapist
16.6(272) School social worker
16.7(272) Special education nurse
16.8(272) Speech-language pathologist

CHAPTER 17
Reserved

CHAPTER 18
ISSUANCE OF ADMINISTRATOR LICENSES AND ENDORSEMENTS
18.1(272) All applicants desiring an Iowa administrator license
18.2 and 18.3 Reserved
18.4(272) General requirements for an administrator license
18.5(272) Specific requirements for a professional administrator license
18.6(272) Specific requirements for an administrator prepared out of state
18.7(272) Specific requirements for a Class A extension license
18.8(272) Specific requirements for a Class B license

18.9(272) Area and grade levels of administrator endorsements
18.10(272) Superintendent/AEA administrator
18.11(272) Director of special education of an area education agency
18.12(272) Specific requirements for a Class E emergency license
18.13 Reserved
18.14(272) Endorsements
18.15(272) Licenses—issue dates, corrections, duplicates, and fraud

CHAPTER 19
EVALUATOR ENDORSEMENT AND LICENSE

19.1(272) Evaluator endorsement and license
19.2(272) Initial evaluator endorsement
19.3(272) Evaluator endorsement
19.4(272) Applicants for administrator licensure
19.5(272) Evaluator license
19.6 Reserved
19.7(272) Renewal of administrator licenses
19.8(272) Renewal of evaluator endorsement or license
19.9(272) Holder of permanent professional certificate
19.10(272) Licenses—issue dates, corrections, duplicates, and fraud

CHAPTER 20
RENEWALS

20.1(272) General renewal information
20.2(272) Renewal application forms
20.3(272) Renewal of licenses
20.4(272) Specific renewal requirements for the initial license
20.5(272) Specific renewal requirements for the standard license
20.6(272) Specific renewal requirements for a master educator license
20.7(272) Specific renewal requirements for a substitute license
20.8(272) Specific renewal requirements for the initial administrator license
20.9(272) Specific renewal requirements for an administrator license
20.10(272) Renewal requirements for a statement of professional recognition (SPR)
20.11(272) Audit of applications for license renewal
20.12(272) Appeal procedure
20.13(272) Licensure renewal programs

CHAPTER 21
CONVERSION INFORMATION

21.1(272) Classes of certificates
21.2(272) Conversion and renewal of life certificates
21.3(272) Conversion of term certificates issued prior to July 1, 1954

CHAPTER 22
AUTHORIZATIONS

22.1(272) Coaching authorization
22.2(272) Substitute authorization
22.3(272) School business official authorization
22.4(272) Licenses—issue dates, corrections, duplicates, and fraud
22.5(272) Preliminary native language teaching authorization
22.6(272) Native language teaching authorization
22.7(272) School administration manager authorization
22.8(272) iJAG authorization

22.9(272) Requirements for the career and technical secondary authorization
22.10(272) Activities administration authorization
22.11(272) Extension

CHAPTER 23
BEHIND-THE-WHEEL DRIVING INSTRUCTOR AUTHORIZATION
23.1(272,321) Requirements
23.2(272,321) Validity
23.3(272,321) Approval of courses
23.4(272,321) Application process
23.5(272,321) Renewal
23.6(272,321) Revocation and suspension

CHAPTER 24
PARAEDUCATOR CERTIFICATES
24.1(272) Paraeducator certificates
24.2(272) Approved paraeducator certificate programs
24.3(272) Prekindergarten through grade 12 paraeducator generalist certificate
24.4(272) Paraeducator area of concentration
24.5(272) Prekindergarten through grade 12 advanced paraeducator certificate
24.6(272) Renewal requirements
24.7(272) Issue date on original certificate
24.8(272) Validity
24.9(272) Certificate application fee

CHAPTER 25
CODE OF PROFESSIONAL CONDUCT AND ETHICS
25.1(272) Scope of standards
25.2(272) Definitions
25.3(272) Standards of professional conduct and ethics

CHAPTER 26
CODE OF RIGHTS AND RESPONSIBILITIES
26.1(272) Purpose
26.2(272) Rights
26.3(272) Responsibilities

CHAPTER 27
ISSUANCE OF PROFESSIONAL SERVICE LICENSES
27.1(272) Professional service license
27.2(272) Requirements for a professional service license
27.3(272) Specific requirements for professional service license endorsements
27.4(272) Specific renewal requirements for the initial professional service license
27.5(272) Specific renewal requirements for the standard professional service license
27.6(272) Specific requirements for a Class B license
27.7(272) Timely renewal

CHAPTER 1
GENERAL

[Prior to 6/15/88, see Professional Teaching Practices Commission[640] Ch 1]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 1]

282—1.1(272) Definition. The board of educational examiners shall hereinafter be referred to as the "board."

This rule is intended to implement Iowa Code chapter 272.

282—1.2(272,17A) Organization and method of operation.

1.2(1) *History.* The board was created by Iowa Code chapter 272.

1.2(2) *Composition.* The composition of the board is defined in Iowa Code section 272.3.

1.2(3) *Executive director.* The governor shall appoint an executive director of the board subject to confirmation by the senate. The executive director shall possess a background in education licensure and administrative experience and shall serve at the pleasure of the governor. The executive director acts as executive head of the agency and is responsible for the administration of the board.

1.2(4) *Major statutory function.* The board is created to exercise the exclusive authority to license practitioners and professional development programs, except for programs offered by practitioner preparation institutions or area education agencies and approved by the state board of education. Licensing authority includes the authority to establish criteria for the licenses, creation of application and renewal forms, development of a code of professional rights and responsibilities, practices, and ethics.

1.2(5) *Conduct of business.* The ordinary business of the board is conducted at its regular meetings generally held at the Grimes State Office Building, Des Moines, Iowa.

a. The board shall biennially, at its regularly scheduled meeting in June, elect a chair from its membership to begin serving upon election.

b. The board shall approve annual meeting dates at least by June 30.

c. The board may schedule special meetings called by the chair or upon request to the chair by six members of the board or upon request of the executive director. Special meetings may be held by electronic means in accordance with Iowa Code section 21.8.

d. The board will post the date, time, and location of board meetings.

e. Persons who wish to submit materials for the agenda and appear before the board, or whose presence has been requested by the board, will be provided the opportunity to address the board.

f. In order to be placed on the agenda, materials must be received at least two weeks prior to a scheduled board meeting. Materials from emergency or unusual circumstances may be added to the agenda with the chair's approval.

g. The board will govern its meetings in accordance with Iowa Code chapter 21 and its proceedings by Robert's Rules of Order, Revised.

h. All board meetings shall be open, and the public shall be permitted to attend the meetings, unless the board votes to hold a closed session in accordance with Iowa Code section 21.5.

i. Persons in attendance at board meetings may be granted an opportunity to speak on an issue before the board at the discretion of the chair. The length and frequency of public comment will be at the discretion of the chair.

j. Information, submissions or requests. General inquiries regarding the board, requests for forms and other documents and all other requests and submissions may be addressed to the Executive Director, Board of Educational Examiners, Grimes State Office Building, Des Moines, Iowa 50319-0147.

This rule is intended to implement Iowa Code chapter 272.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

[Filed July 12, 1973]
[Filed 10/6/75, Notice 8/25/75—published 10/20/75, effective 11/24/75]
[Filed emergency 7/2/86—published 7/30/86, effective 7/2/86]
[Filed emergency 5/25/88—published 6/15/88, effective 5/25/88]
[Filed emergency 4/26/90—published 5/16/90, effective 4/27/90]

[Filed 5/20/92, Notice 2/19/92—published 6/10/92, effective 7/15/92]
[Filed emergency 2/21/95—published 3/15/95, effective 2/21/95]
[Filed 10/15/07, Notice 8/1/07—published 11/7/07, effective 12/12/07]
[Filed ARC 0026C (Notice ARC 9924B, IAB 12/14/11), IAB 3/7/12, effective 4/11/12]
[Filed ARC 3196C (Notice ARC 3012C, IAB 4/12/17), IAB 7/5/17, effective 8/9/17]

CHAPTER 11
COMPLAINTS, INVESTIGATIONS, CONTESTED CASE HEARINGS

[Prior to 6/15/88, see Professional Teaching Practices Commission[640] Ch 2]
[Prior to 5/16/90, see Professional Teaching Practices Commission[287] Ch 2]

282—11.1(17A,272) Scope and applicability. This chapter applies to contested case proceedings conducted by the board of educational examiners.

282—11.2(17A) Definitions. Except where otherwise specifically defined by law:

"Board" means the board of educational examiners.

"Complainant" means any qualified party who files a complaint with the board.

"Contested case" means a proceeding defined by Iowa Code section 17A.2(5) and includes any matter defined as a no factual dispute contested case under Iowa Code section 17A.10A.

"Issuance" means the date of mailing of a decision or order or date of delivery if service is by other means unless another date is specified in the order.

"Party" means each person or agency named or admitted as a party or properly seeking and entitled as of right to be admitted as a party.

"Presiding officer" means an administrative law judge from the Iowa department of inspections and appeals or the full board or a three-member panel of the board.

"Proposed decision" means the presiding officer's recommended findings of fact, conclusions of law, decision, and order in a contested case in which the full board did not preside.

"Respondent" means any individual who is charged in a complaint with violating the criteria of professional practices or the criteria of competent performance.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.3(17A,272) Jurisdictional requirements.

11.3(1) The case must relate to alleged violation of the criteria of professional practices or the criteria of competent performance.

11.3(2) The magnitude of the alleged violation must be adequate to warrant a hearing by the board.

11.3(3) There must be sufficient evidence to support the complaint.

11.3(4) The complaint must be filed by a person who has personal knowledge of an alleged violation and must include a concise statement of facts which clearly and specifically apprises the respondent of the details of the allegation(s).

11.3(5) The complaint must be filed within three years of the occurrence of the conduct upon which it is based or discovery of the conduct by the complainant unless good cause can be shown for extension of this limitation.

11.3(6) The jurisdictional requirements must be met on the face of the complaint before the board may order an investigation of the allegation(s) of the complaint.

11.3(7) As an additional factor, it should appear that a reasonable effort has been made to resolve the problem on the local level. However, the absence of such an effort shall not preclude investigation by the board.

282—11.4(17A,272) Complaint.

11.4(1) *Who may initiate.* The following entities may initiate a complaint:

a. Licensed practitioners.

b. Recognized educational entities or local or state professional organizations.

c. Local boards of education.

d. Parents or guardians of students involved in the alleged complaint.

e. The executive director of the board of educational examiners if the following circumstances have been met:

(1) The executive director receives information that a practitioner:

1. Has been convicted of a felony criminal offense, or a misdemeanor criminal offense wherein the victim of the crime was 18 years of age or younger, and the executive director expressly determines within the complaint that the nature of the offense clearly and directly impacts the practitioner's fitness or ability to retain the specific license(s) or authorization(s) which the practitioner holds; or

2. Has been the subject of a founded report of child abuse placed upon the central registry maintained by the department of human services pursuant to Iowa Code section 232.71D and the executive director expressly determines within the complaint that the nature of the offense clearly and directly impacts the practitioner's fitness or ability to retain the specific license(s) or authorization(s) which the practitioner holds; or

3. Has not met a reporting requirement stipulated by Iowa Code section 272.15, Iowa Code section 279.43, 281—subrule 102.11(2), 282—Chapter 11, or 282—Chapter 25; or

4. Has falsified a license or authorization issued by the board; or

5. Has submitted false information on a license or authorization application filed with the board; or

6. Does not hold the appropriate license for the assignment for which the practitioner is currently employed; or

7. Has assigned another practitioner to perform services for which the practitioner is not properly licensed; or

8. Has failed to comply with a board order as prohibited by 282—paragraph 25.3(7)*"d"*; and

(2) The executive director verifies the information or the alleged misconduct through review of official records maintained by the board, a court, the department of human services registry of founded child abuse reports, the practitioner licensing authority of another state, the department of education, the local school district, area education agency, or authorities in charge of the nonpublic school, or the executive director is presented with the falsified license; and

(3) No other complaint has been filed.

f. The department of transportation if the licensee named in the complaint holds a behind-the-wheel instructor's certification issued by the department and the complaint relates to an incident or incidents arising during the course of driver's education instruction.

g. An employee of the department of education who, while performing official duties, becomes aware of any alleged misconduct by an individual licensed under Iowa Code section 272.2.

11.4(2) *Form and content of the complaint.*

a. The complaint shall be in writing and signed by at least one complainant who has personal knowledge of an alleged violation of the board's rules or related state law or an authorized representative if the complainant is an organization. (An official form may be used. This form may be obtained from the board upon request.)

b. The complaint shall show venue as "BEFORE THE BOARD OF EDUCATIONAL EXAMINERS" and shall be captioned "COMPLAINT."

c. The complaint shall contain the following information:

(1) The full name, address and telephone number of the complainant.

(2) The full name, address and telephone number, if known, of the respondent.

(3) A concise statement of the facts which clearly and specifically apprises the respondent of the details of the alleged violation of the criteria of professional practices or the criteria of competent performance and the relief sought by the complainant.

(4) An explanation of the basis of the complainant's personal knowledge of the facts underlying the complaint.

(5) A citation to the specific rule or law which the complainant alleges has been violated.

11.4(3) *Required copies—place and time of filing the complaint.*

a. A copy of the complaint must be filed with the board.

b. The complaint must be delivered personally or by mail to the office of the board. The current office address is the Grimes State Office Building, Third Floor, Des Moines, Iowa 50319-0147.

c. Timely filing is required in order to ensure the availability of witnesses and to avoid initiation of an investigation under conditions which may have been significantly altered during the period of delay.

The conduct upon which it is based must have occurred or been discovered by the complainant within three years of filing of the complaint unless good cause is shown for an extension of this limitation.

11.4(4) *Amendment or withdrawal of complaint.* A complaint or any specification thereof may be amended or withdrawn by the complainant at any time, unless the complaint was filed in accordance with the mandatory reporting requirements set forth in Iowa Code section 272.15(1). The parties to a complaint may mutually agree to the resolution of the complaint at any time in the proceeding prior to issuance of a final order by the board. The resolution must be committed to a written agreement and filed with the board. The agreement is not subject to approval by the board, but shall be acknowledged by the board and may be incorporated into an order of the board.

11.4(5) *Respondent entitled to copy of the complaint.* Immediately upon the board's determination that jurisdictional requirements have been met, the respondent shall be provided a copy of the complaint or amended complaint and any supporting documents attached to the complaint at the time of filing.

11.4(6) *Voluntary surrender of license—agreement to accept lesser sanction.* A practitioner may voluntarily surrender the practitioner's license or agree to accept a lesser sanction from the board prior to or after the filing of a complaint with the board without admitting the truth of the allegations of the complaint if a complaint is on file with the board. In order to voluntarily surrender a license or submit to a sanction, the practitioner must waive the right to hearing before the board and notify the board of the intent to surrender or accept sanction. The board may issue an order permanently revoking the practitioner's license if it is surrendered, or implementing the agreed upon sanction. The board may decline to issue an agreed upon sanction if, in the board's judgment, the agreed upon sanction is not appropriate for the circumstances of the case.

11.4(7) *Investigation of license reports.*

a. Reports received by the board from another state, territory or other jurisdiction concerning licenses or certificate revocation or suspension shall be reviewed and investigated by the board in the same manner as is prescribed in these rules for the review and investigation of written complaints.

b. Failure to report a license revocation, suspension or other disciplinary action taken by licensing authority of another state, territory or jurisdiction within 30 days of the final action by such licensing authority shall constitute cause for initiation of an investigation.

11.4(8) *Timely resolution of complaints.* Complaints filed with the board must be resolved within 180 days unless good cause can be shown for an extension of this limitation. The board will provide notice to the parties to a complaint prior to taking action to extend this time limitation upon its own motion.

11.4(9) *Confidentiality.* All complaint files, investigation files, other investigation reports, and other investigation information in the possession of the board or its employees or agents, which relate to licensee discipline, are privileged and confidential, and are not subject to discovery, subpoena, or other means of legal compulsion for their release to a person other than the respondent and the board and its employees and agents involved in licensee discipline, and are not admissible in evidence in a judicial or administrative proceeding other than the proceeding involving licensee discipline. However, investigative information in the possession of the board or its employees or agents which is related to licensee discipline may be disclosed to appropriate licensing authorities within this state, the appropriate licensing authorities in another state, the District of Columbia, or a territory or country in which the licensee is licensed or has applied for a license. A final written decision and finding of fact by the board in a disciplinary proceeding is a public record.

[**ARC 8406B**, IAB 12/16/09, effective 1/20/10 (See Delay note at end of chapter); **ARC 8823B**, IAB 6/2/10, effective 5/14/10; **ARC 0026C**, IAB 3/7/12, effective 4/11/12; **ARC 0853C**, IAB 7/24/13, effective 8/28/13; **ARC 1455C**, IAB 5/14/14, effective 6/18/14; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

282—11.5(272) Investigation of complaints or license reports. The chairperson of the board or the chairperson's designee may request an investigator to investigate the complaint or report received by the board from another state, territory or other jurisdiction concerning license or certificate revocation or suspension pursuant to subrule 11.4(7); providing that the jurisdictional requirements have been met on the face of the complaint. The investigation shall be limited to the allegations contained on the face of the complaint. The investigator may consult an assistant attorney general concerning the investigation or

evidence produced from the investigation. Upon completion of the investigation, the investigator shall prepare a report of the investigation for consideration by the board in determining whether probable cause exists.

282—11.6(272) Ruling on the initial inquiry. Upon review of the investigator's report, the board may take any of the following actions:

11.6(1) Reject the case. If a determination is made by the board to reject the case, the complaint shall be returned to the complainant along with a statement specifying the reasons for rejection. A letter of explanation concerning the decision of the board shall be sent to the respondent.

11.6(2) Require further inquiry. If determination is made by the board to order further inquiry, the complaint and recommendations by the investigator(s) shall be returned to the investigator(s) along with a statement specifying the information deemed necessary.

11.6(3) Accept the case. If a determination is made by the board that probable cause exists to conclude that the criteria of professional practices or the criteria of competent performance have been violated, notice may be issued, pursuant to rule 282—11.7(17A,272), and a formal hearing may be conducted in accordance with rules 282—11.7(17A,272) to 282—11.21(17A,272), unless a voluntary waiver of hearing has been filed by the respondent pursuant to the provisions of subrule 11.4(6). In determining whether to issue a notice of hearing, the board may consider the following:

a. Whether the alleged violation is of sufficient magnitude to warrant a hearing by the board.

b. Whether there is sufficient evidence to support the complaint.

c. Whether the alleged violation was an isolated incident.

d. Whether adequate steps have been taken at the local level to ensure similar behavior does not occur in the future.

11.6(4) Release of investigative report. If the board finds probable cause of a violation, the investigative report will be available to the respondent upon request. Information contained within the report is confidential and may be used only in connection with the disciplinary proceedings before the board.

[**ARC 1543C**, IAB 7/23/14, effective 8/27/14]

282—11.7(17A,272) Notice of hearing.

11.7(1) *Delivery.* Delivery of the notice of hearing constitutes the commencement of the contested case proceeding. Delivery may be executed by:

a. Personal service as provided in the Iowa Rules of Civil Procedure; or

b. Certified mail, return receipt requested; or

c. Publication, as provided in the Iowa Rules of Civil Procedure.

11.7(2) *Contents.* The notice of hearing shall contain the following information:

a. A statement of the time, date, place, and nature of the hearing;

b. A statement of the legal authority and jurisdiction under which the hearing is to be held;

c. A reference to the particular sections of the statutes and rules involved;

d. A short and plain statement of the matter asserted;

e. Identification of all parties including the name, address and telephone numbers of counsel representing each of the parties where known;

f. Reference to the procedural rules governing conduct of the contested case proceeding;

g. Identification of the presiding officer, if known. If not known, a description of who will serve as presiding officer; and

h. Notification of the time period in which a party may request, pursuant to Iowa Code section 17A.11 and rule 282—11.8(17A,272), that the presiding officer be an administrative law judge.

[**ARC 0606C**, IAB 2/20/13, effective 3/27/13]

282—11.8(17A,272) Presiding officer.

11.8(1) Any party who wishes to request that the presiding officer assigned to render a proposed decision be an administrative law judge employed by the department of inspections and appeals must

file a written request within 20 days after service of a notice of hearing which identifies or describes the presiding officer as the board.

11.8(2) The board may deny the request only upon a finding that one or more of the following apply:

a. Neither the board nor any officer of the board under whose authority the contested case is to take place is a named party to the proceeding or a real party in interest to that proceeding.

b. There is a compelling need to expedite issuance of a final decision in order to protect the public health, safety, or welfare.

c. An administrative law judge with the qualifications identified in subrule 11.8(4) is unavailable to hear the case within a reasonable time.

d. The case involves significant policy issues of first impression that are inextricably intertwined with the factual issues presented.

e. The demeanor of the witnesses is likely to be dispositive in resolving the disputed factual issues.

f. Funds are unavailable to pay the costs of an administrative law judge and an interagency appeal.

g. The request was not timely filed.

h. The request is not consistent with a specified statute.

11.8(3) The board shall issue a written ruling specifying the grounds for its decision within 20 days after a request for an administrative law judge is filed. If the ruling is contingent upon the availability of an administrative law judge with the qualifications identified in subrule 11.8(4), the parties shall be notified at least 10 days prior to hearing if a qualified administrative law judge will not be available.

11.8(4) An administrative law judge assigned to act as presiding officer in a contested case shall have the following technical expertness unless waived by the board:

a. A J.D. degree.

b. Additional criteria may be added by the board.

11.8(5) Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the board. A party must seek any available intra-agency appeal in order to exhaust adequate administrative remedies.

11.8(6) Unless otherwise provided by law, the board, when reviewing a proposed decision upon intra-agency appeal, shall have the powers of and shall comply with the provisions of this chapter which apply to presiding officers.

282—11.9(17A,272) Waiver of procedures. Unless otherwise precluded by law, the parties in a contested case proceeding may waive any provision of this chapter. However, the board in its discretion may refuse to give effect to such a waiver when it deems the waiver to be inconsistent with the public interest.

282—11.10(17A,272) Telephone proceedings. The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearings. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen.

282—11.11(17A,272) Disqualification.

11.11(1) A presiding officer or board member shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

a. Has a personal bias or prejudice concerning a party or a representative of a party;

b. Has personally investigated, prosecuted or advocated in connection with that case, the specific controversy underlying that case, another pending factually related contested case, or a pending factually related controversy that may culminate in a contested case involving the same parties;

c. Is subject to the authority, direction or discretion of any person who has personally investigated, prosecuted or advocated in connection with that contested case, the specific controversy underlying that contested case, or a pending factually related contested case or controversy involving the same parties;

d. Has acted as counsel to any person who is a private party to that proceeding within the past two years;

e. Has a personal financial interest in the outcome of the case or any other significant personal interest that could be substantially affected by the outcome of the case;

f. Has a spouse or relative within the third degree of relationship that: (1) is a party to the case, or an officer, director or trustee of a party; (2) is a lawyer in the case; (3) is known to have an interest that could be substantially affected by the outcome of the case; or (4) is likely to be a material witness in the case; or

g. Has any other legally sufficient cause to withdraw from participation in the decision making in that case.

11.11(2) The term "personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other agency functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by Iowa Code section 17A.17 and subrules 11.11(3) and 11.24(9).

11.11(3) In a situation where a presiding officer or board member knows of information which might reasonably be deemed to be a basis for disqualification and decides voluntary withdrawal is unnecessary, that person shall submit the relevant information for the record by affidavit and shall provide for the record a statement of the reasons for the determination that withdrawal is unnecessary.

11.11(4) If a party asserts disqualification on any appropriate ground, including those listed in subrule 11.11(1), the party shall file a motion supported by an affidavit pursuant to Iowa Code section 17A.17(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party.

If the presiding officer determines that disqualification is appropriate, the presiding officer or board member shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal under rule 282—11.26(17A,272) and seek a stay under rule 282—11.30(17A,272).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.12(17A,272) Consolidation—severance.

11.12(1) *Consolidation.* The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where: (a) the matters at issue involve common parties or common questions of fact or law; (b) consolidation would expedite and simplify consideration of the issues involved; and (c) consolidation would not adversely affect the rights of any of the parties to those proceedings.

11.12(2) *Severance.* The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

282—11.13(17A,272) Pleadings.

11.13(1) Pleadings may be required by rule, by the notice of hearing, or by order of the presiding officer.

11.13(2) Answer. An answer shall be filed within 20 days of service of the notice of hearing unless otherwise ordered. A party may move to dismiss or apply for a more definite and detailed statement when appropriate.

An answer shall show on whose behalf it is filed and specifically admit, deny, or otherwise answer all material allegations of the notice of hearing to which it responds. It shall state any facts deemed to show an affirmative defense and contain as many additional defenses as the pleader may claim.

An answer shall state the name, address and telephone number of the person filing the answer, the person or entity on whose behalf it is filed, and the attorney representing that person, if any.

Any allegation in the notice of hearing not denied in the answer is considered admitted. The presiding officer may refuse to consider any defense not raised in the answer which could have been raised on the basis of facts known when the answer was filed if any party would be prejudiced.

11.13(3) Amendment. Notices of hearing and answers may be amended with the consent of the parties or in the discretion of the presiding officer who may impose terms or grant a continuance.

282—11.14(17A,272) Service and filing of pleadings and other papers.

11.14(1) *Service—when required.* Except where otherwise provided by law, every document filed in a contested case proceeding shall be served upon each of the parties of record to the proceeding, simultaneously with their filing. Except for the original notice of hearing and an application for rehearing as provided in Iowa Code section 17A.16(2), the party filing a document is responsible for service on all parties.

11.14(2) *Service—how made.* Service upon a party represented by an attorney shall be made upon the attorney unless otherwise ordered. Service is made by delivery or by mailing a copy to the person's last-known address. Service by mail is complete upon mailing, except where otherwise specifically provided by statute, rule, or order.

11.14(3) *Filing—when required.* After the notice of hearing, all documents in a contested case proceeding shall be filed with the Board of Educational Examiners, Grimes State Office Building, Des Moines, Iowa 50319-0147. All documents that are required to be served upon a party shall be filed simultaneously with the board.

11.14(4) *Filing—when made.* Except where otherwise provided by law, a document is deemed filed at the time it is delivered to the board, delivered to an established courier service for immediate delivery to that office, or mailed by first-class mail or state interoffice mail to that office, so long as there is proof of mailing.

11.14(5) *Proof of mailing.* Proof of mailing includes either: a legible United States Postal Service postmark on the envelope, a certificate of service, a notarized affidavit, or a certification in substantially the following form:

> I certify under penalty of perjury and pursuant to the laws of Iowa that, on (date of mailing), I mailed copies of (describe document) addressed to the (agency office and address) and to the names and addresses of the parties listed below by depositing the same in (a United States post office mailbox with correct postage properly affixed or state interoffice mail).
>
> (Date) (Signature)

282—11.15(17A,272) Discovery.

11.15(1) Discovery procedures applicable in civil actions are applicable in contested cases. Unless lengthened or shortened by these rules or by order of the presiding officer, time periods for compliance with discovery shall be as provided in the Iowa Rules of Civil Procedure.

11.15(2) Any motion relating to discovery shall allege that the moving party has previously made a good-faith attempt to resolve the discovery issues involved with the opposing party. Motions in regard to discovery shall be ruled upon by the presiding officer. Opposing parties shall be afforded the opportunity to respond within ten days of the filing of the motion unless the time is shortened as provided in subrule 11.15(1). The presiding officer may rule on the basis of the written motion and any response, or may order argument on the motion.

11.15(3) Evidence obtained in discovery may be used in the contested case proceeding if that evidence would otherwise be admissible under rule 282—11.22(17A,272). In discovery matters, the parties shall honor the rules of privilege imposed by law.

282—11.16(17A,272) Subpoenas.

11.16(1) *Subpoenas.* In connection with the investigation set forth in rule 282—11.5(272), the board is authorized by law to subpoena books, papers, records and any other evidence to help it determine whether it should institute a contested case proceeding (hearing). After service of the hearing notification contemplated by rule 282—11.7(17A,272), the following procedures are available to the parties in order to obtain relevant and material evidence:

a. Board subpoenas for books, papers, records, and other evidence will be issued to a party upon request. Such a request must be in writing. Application should be made to the board office specifying the evidence sought. Subpoenas for witnesses may also be obtained.

b. Evidence obtained by subpoena shall be admissible at the hearing if it is otherwise admissible under rule 282—11.22(17A,272). In subpoena matters the parties shall honor the rules of privilege imposed by law.

c. The evidence outlined in Iowa Code section 17A.13(2) where applicable and relevant shall be made available to a party upon request.

d. Except to the extent otherwise provided by law, parties are responsible for service of their own subpoenas and payment of witness fees and mileage expenses.

11.16(2) *Motion to quash or modify.* The presiding officer may quash or modify a subpoena for any lawful reason upon motion in accordance with the Iowa Rules of Civil Procedure. A motion to quash or modify a subpoena shall be set for argument promptly.

282—11.17(17A,272) Motions.

11.17(1) No technical form for motions is required. However, prehearing motions must be in writing, state the grounds for relief, and state the relief sought.

11.17(2) Any party may file a written response to a motion within ten days after the motion is served, unless the time period is extended or shortened by rules of the agency or the presiding officer.

11.17(3) The presiding officer may schedule oral arguments on any motion.

11.17(4) Motions pertaining to the hearing, including motions for summary judgment, must be filed and served at least ten days prior to the date of hearing unless there is good cause for permitting later action or the time for such action is lengthened or shortened by rule of the agency or an order of the presiding officer.

282—11.18(17A,272) Prehearing conference.

11.18(1) Any party may request a prehearing conference. A written request for prehearing conference or an order for prehearing conference on the presiding officer's own motion shall be filed not less than seven days prior to the hearing date. A prehearing conference shall be conducted not less than three business days prior to the hearing date.

Written notice of the prehearing conference shall be given by the presiding officer to all parties. For good cause the presiding officer may permit variances from this rule.

11.18(2) Each party shall bring to the prehearing conference:

a. A final list of the witnesses who the party anticipates will testify at hearing. Witnesses not listed may be excluded from testifying unless there was good cause for the failure to include their names; and

b. A final list of exhibits which the party anticipates will be introduced at hearing. Exhibits other than rebuttal exhibits that are not listed may be excluded from admission into evidence unless there was good cause for the failure to include them.

c. Witness or exhibit lists may be amended subsequent to the prehearing conference within the time limits established by the presiding officer at the prehearing conference. Any such amendments must be served on all parties.

11.18(3) In addition to the requirements of subrule 11.18(2), the parties at a prehearing conference may:

a. Enter into stipulations of law or fact;

b. Enter into stipulations on the admissibility of exhibits;

c. Identify matters which the parties intend to request be officially noticed;

d. Enter into stipulations for waiver of any provision of law; and

e. Consider any additional matters which will expedite the hearing.

11.18(4) Prehearing conferences shall be conducted by telephone unless otherwise ordered. Parties shall exchange and receive witness and exhibit lists in advance of a telephone prehearing conference.

282—11.19(17A,272) Continuances. A party has no automatic right to a continuance or delay of the board's hearing procedure or schedule. However, a party may request a continuance of the presiding officer no later than seven days prior to the date set for hearing. The presiding officer shall have the power to grant continuances. Within seven days of the date set for hearing, no continuances shall be granted except for extraordinary, extenuating or emergency circumstances. In these situations, the presiding officer shall grant continuances after consultation, if needed, with the chairperson of the board, the executive director, or the attorney representing the board. A board member shall not be contacted in person, by mail or telephone by a party seeking a continuance.

282—11.20(17A,272) Intervention.

11.20(1) *Motion.* A motion for leave to intervene in a contested case proceeding shall state the grounds for the proposed intervention, the position and interest of the proposed intervenor, and the possible impact of intervention on the proceeding. A proposed answer or petition in intervention shall be attached to the motion. Any party may file a response within 14 days of service of the motion to intervene unless the time period is extended or shortened by the presiding officer.

11.20(2) *When filed.* Motion for leave to intervene shall be filed as early in the proceeding as possible to avoid adverse impact on existing parties or the conduct of the proceeding. Unless otherwise ordered, a motion for leave to intervene shall be filed before the prehearing conference, if any, or at least 20 days before the date scheduled for hearing. Any later motion must contain a statement of good cause for the failure to file in a timely manner. Unless inequitable or unjust, an intervenor shall be bound by any agreement, arrangement, or other matter previously raised in the case. Requests by untimely intervenors for continuances which would delay the proceeding will ordinarily be denied.

11.20(3) *Grounds for intervention.* The movant shall demonstrate that: (a) intervention would not unduly prolong the proceedings or otherwise prejudice the rights of existing parties; (b) the movant is likely to be aggrieved or adversely affected by a final order in the proceeding; and (c) the interests of the movant are not adequately represented by existing parties.

11.20(4) *Effect of intervention.* If appropriate, the presiding officer may order consolidation of the petitions and briefs of different parties whose interests are aligned with each other and limit the number of representatives allowed to participate actively in the proceedings. A person granted leave to intervene is a party to the proceeding. The order granting intervention may restrict the issues that may be raised by the intervenor or otherwise condition the intervenor's participation in the proceeding.

282—11.21(17A,272) Hearing procedures.

11.21(1) The presiding officer presides at the hearing and may rule on motions, require briefs, issue a proposed decision, and issue such orders and rulings as will ensure the orderly conduct of the proceedings. If the presiding officer is the board or a panel thereof, an administrative law judge from the Iowa department of inspections and appeals may be designated to assist the board in conducting proceedings under this chapter. An administrative law judge so designated may rule upon motions and other procedural matters and assist the board in conducting the hearing.

11.21(2) All objections shall be timely made and stated on the record.

11.21(3) Legal representation.

a. The respondent has a right to participate in all hearings or prehearing conferences and may be represented by an attorney or another person authorized by law.

b. The office of the attorney general or an attorney designated by the executive director shall be responsible for prosecuting complaint allegations in all contested case proceedings before the board, except those cases in which the sole allegation involves the failure of a practitioner to fulfill contractual obligations. The assistant attorney general or other designated attorney assigned to prosecute a contested

case before the board shall not represent the board or the complainant in that case, but shall represent the public interest.

c. In a case in which the sole allegation involves the failure of a practitioner to fulfill contractual obligations, the person who files the complaint with the board, or the complainant's designee, shall represent the complainant during the contested case proceedings.

11.21(4) Subject to terms and conditions prescribed by the presiding officer, parties have the right to introduce evidence on issues of material fact, cross-examine witnesses present at the hearing as necessary for a full and true disclosure of the facts, present evidence in rebuttal, and submit briefs and engage in oral argument.

11.21(5) The presiding officer shall maintain the decorum of the hearing and may refuse to admit or may expel anyone whose conduct is disorderly.

11.21(6) Witnesses may be sequestered during the hearing.

11.21(7) The presiding officer shall conduct the hearing in the following manner:

a. The presiding officer shall give an opening statement briefly describing the nature of the proceedings;

b. The parties shall be given an opportunity to present opening statements;

c. Parties shall present their cases in the sequence determined by the presiding officer;

d. Each witness shall be sworn or affirmed by the presiding officer or the court reporter and be subject to examination and cross-examination. The presiding officer may limit questioning in a manner consistent with law;

e. When all parties and witnesses have been heard, parties may be given the opportunity to present final arguments.

282—11.22(17A,272) Evidence.

11.22(1) The presiding officer shall rule on admissibility of evidence and may, where appropriate, take official notice of facts in accordance with all applicable requirements of law.

11.22(2) Stipulation of facts is encouraged. The presiding officer may make a decision based on stipulated facts.

11.22(3) Evidence in the proceeding shall be confined to the issues concerning allegations raised on the face of the complaint as to which the parties received notice prior to the hearing.

11.22(4) The party seeking admission of an exhibit must provide opposing parties with an opportunity to examine the exhibit prior to the ruling on its admissibility. Copies of documents should normally be provided to opposing parties.

All exhibits admitted into evidence shall be appropriately marked and be made part of the record.

11.22(5) Any party may object to specific evidence or may request limits on the scope of any examination or cross-examination. Such an objection shall be accompanied by a brief statement of the grounds upon which it is based. The objection, the ruling on the objection, and the reasons for the ruling shall be noted in the record. The presiding officer may rule on the objection at the time it is made or may reserve a ruling until the written decision.

11.22(6) Whenever evidence is ruled inadmissible, the party offering that evidence may submit an offer of proof on the record. The party making the offer of proof for excluded oral testimony shall briefly summarize the testimony or, with permission of the presiding officer, present the testimony. If the excluded evidence consists of a document or exhibit, it shall be marked as part of an offer of proof and inserted in the record.

282—11.23(17A,272) Default.

11.23(1) If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

11.23(2) Where appropriate and not contrary to law, any party may move for default against a party who has requested the contested case proceeding and has failed to file a required pleading or has failed to appear after proper service.

11.23(3) Default decisions or decisions rendered on the merits after a party has failed to appear or participate in a contested case proceeding become final agency action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided by rule 282—11.28(17A,272). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, which affidavit(s) must be attached to the motion.

11.23(4) The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

11.23(5) Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

11.23(6) "Good cause" for purposes of this rule shall have the same meaning as "good cause" for setting aside a default judgment under Iowa Rule of Civil Procedure 1.977.

11.23(7) A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party pursuant to rule 282—11.26(17A,272).

11.23(8) If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

11.23(9) A default decision may award any relief consistent with the request for relief made in the petition and embraced in its issues (but, unless the defaulting party has appeared, it cannot exceed the relief demanded).

11.23(10) A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for stay under rule 282—11.30(17A,272).

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.24(17A,272) Ex parte communication.

11.24(1) Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the board or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in subrule 11.11(2), prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

11.24(2) Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

11.24(3) Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

11.24(4) To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rule 282—11.13(17A,272) and may be supplemented by telephone,

facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone call including all parties or their representatives.

11.24(5) Board members acting as presiding officers may communicate with each other without notice or opportunity for parties to participate.

11.24(6) The executive director or other persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with subrule 11.24(1).

11.24(7) Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines pursuant to rule 282—11.19(17A,272).

11.24(8) Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication shall be submitted for inclusion in the record under seal by protective order (or disclosed). If the presiding officer determines that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

11.24(9) Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

11.24(10) The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule including default, a decision against the offending party, censure, or suspension or revocation of the privilege to practice before the department. Violation of ex parte communication prohibitions by department personnel shall be reported to (agency to designate person to whom violations should be reported) for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

282—11.25(17A,272) Recording costs. Upon request, the board shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

282—11.26(17A,272) Interlocutory appeals. Upon written request of a party or on its own motion, the board may review an interlocutory order of the presiding officer. In determining whether to do so, the board shall weigh the extent to which its granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the board at the time it reviews the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

282—11.27(17A,272) Final decision.

11.27(1) When the board presides over the reception of evidence at the hearing, its decision is a final decision.

11.27(2) When the board does not preside at the reception of evidence, the presiding officer shall make a proposed decision. The proposed decision becomes the final decision of the board without further proceedings unless there is an appeal to, or review on motion of, the board within the time provided in rule 282—11.28(17A,272).

282—11.28(17A,272) Appeals and review.

11.28(1) *Appeal by party.* Any adversely affected party may appeal a proposed decision to the board within 30 days after issuance of the proposed decision.

11.28(2) *Review.* The board may initiate review of a proposed decision on its own motion at any time within 30 days following the issuance of such a decision.

11.28(3) *Notice of appeal.* An appeal of a proposed decision is initiated by filing a timely notice of appeal with the board. The notice of appeal must be signed by the appealing party or a representative of that party and contain a certificate of service. The notice shall specify:

a. The parties initiating the appeal;

b. The proposed decision or order appealed from;

c. The specific findings or conclusions to which exception is taken and any other exceptions to the decision or order;

d. The relief sought;

e. The grounds for relief.

11.28(4) *Requests to present additional evidence.* A party may request the taking of additional evidence only by establishing that the evidence is material, that good cause existed for the failure to present the evidence at the hearing, and that the party has not waived the right to present the evidence. A written request to present additional evidence must be filed with the notice of appeal or, by a nonappealing party, within 14 days of service of the notice of appeal. The board may remand a case to the presiding officer for further hearing or may itself preside at the taking of additional evidence.

11.28(5) *Scheduling.* The board shall issue a schedule for consideration of the appeal.

11.28(6) *Briefs and arguments.* Unless otherwise ordered, within 20 days of the notice of appeal or order for review, each appealing party may file exceptions and briefs. Within 20 days thereafter, any party may file a responsive brief. Briefs shall cite any applicable legal authority and specify relevant portions of the record in that proceeding. Written requests to present oral argument shall be filed with the briefs.

The board may resolve the appeal on the briefs or provide an opportunity for oral argument. The board may shorten or extend the briefing period as appropriate.

282—11.29(17A,272) Applications for rehearing.

11.29(1) *By whom filed.* Any party to a contested case proceeding may file an application for rehearing from a final order.

11.29(2) *Content of application.* The application for rehearing shall state on whose behalf it is filed, the specific grounds for rehearing, and the relief sought. In addition, the application shall state whether the applicant desires reconsideration of all or part of the board decision on the existing record and whether, on the basis of the grounds enumerated in subrule 11.28(4), the applicant requests an opportunity to submit additional evidence.

11.29(3) *Time of filing.* The application shall be filed with the board within 20 days after issuance of the final decision.

11.29(4) *Notice to other parties.* A copy of the application shall be timely mailed by the applicant to all parties of record not joining therein. If the application does not contain a certificate of service, the board shall serve copies on all parties.

11.29(5) *Disposition.* Any application for a rehearing shall be deemed denied unless the board grants the application within 20 days after its filing.

282—11.30(17A,272) Stays of board actions.

11.30(1) *When available.*

a. Any party to a contested case proceeding may petition the board for a stay of an order issued in that proceeding or for other temporary remedies, pending review by the board. The petition shall be filed with the notice of appeal and shall state the reasons justifying a stay or other temporary remedy. The executive director may rule on the stay or authorize the presiding officer to do so.

b. Any party to a contested case proceeding may petition the board for a stay or other temporary remedies pending judicial review of all or part of that proceeding. The petition shall state the reasons justifying a stay or other temporary remedy.

11.30(2) *When granted.* In determining whether to grant a stay, the executive director or presiding officer shall consider the factors listed in Iowa Code section 17A.19(5).

11.30(3) *Vacation.* A stay may be vacated by the issuing authority upon application of the board or any other party.

[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.31(17A,272) No factual dispute contested cases. If the parties agree that no dispute of material fact exists as to a matter that would be a contested case if such a dispute of fact existed, the parties may present all relevant admissible evidence either by stipulation or otherwise as agreed by the parties, without necessity for the production of evidence at an evidentiary hearing. If such agreement is reached, a jointly submitted schedule detailing the method and timetable for submission of the record, briefs and oral argument should be submitted to the presiding officer for approval as soon as practicable. If the parties cannot agree, any party may file and serve a motion for summary judgment pursuant to the rules governing such motions.

282—11.32(17A,272) Emergency adjudicative proceedings.

11.32(1) *Necessary emergency action.* To the extent necessary to prevent or avoid immediate danger to the public health, safety, or welfare, and consistent with the Constitution and other provisions of law, the board may issue a written order in compliance with Iowa Code section 17A.18 to suspend a license in whole or in part, order the cessation of any continuing activity, order affirmative action, or take other action within the jurisdiction of the board by emergency adjudicative order. Before issuing an emergency adjudicative order the board shall consider factors including, but not limited to, the following:

a. Whether there has been a sufficient factual investigation to ensure that the board is proceeding on the basis of reliable information;

b. Whether the specific circumstances which pose immediate danger to the public health, safety or welfare have been identified and determined to be continuing;

c. Whether the person required to comply with the emergency adjudicative order may continue to engage in other activities without posing immediate danger to the public health, safety or welfare;

d. Whether imposition of monitoring requirements or other interim safeguards would be sufficient to protect the public health, safety or welfare; and

e. Whether the specific action contemplated by the board is necessary to avoid the immediate danger.

11.32(2) *Issuance of order.*

a. An emergency adjudicative order shall contain findings of fact, conclusions of law, and policy reasons to justify the determination of an immediate danger in the board's decision to take immediate action.

b. The written emergency adjudicative order shall be immediately delivered to persons who are required to comply with the order by utilizing one or more of the following procedures:

(1) Personal delivery;

(2) Certified mail, return receipt requested, to the last address on file with the board;

(3) Certified mail to the last address on file with the board;

(4) First-class mail to the last address on file with the board; or

(5) Fax. Fax may be used as the sole method of delivery if the person required to comply with the order has filed a written request that board orders be sent by fax and has provided a fax number for that purpose.

c. To the degree practicable, the board shall select the procedure for providing written notice that best ensures prompt, reliable delivery.

11.32(3) *Oral notice.* Unless the written emergency adjudicative order is provided by personal delivery on the same day that the order issues, the board shall make reasonable immediate efforts to contact by telephone the persons who are required to comply with the order.

11.32(4) *Completion of proceedings.* After the issuance of an emergency adjudicative order, the board shall proceed as quickly as feasible to complete any proceedings that would be required if the matter did not involve an immediate danger.

Issuance of a written emergency adjudicative order shall include notification of the date on which board proceedings are scheduled for completion. After issuance of an emergency adjudicative order, continuance of further board proceedings to a later date will be granted only in compelling circumstances upon application in writing.

282—11.33(272) Methods of discipline. The board has the authority to impose the following disciplinary sanctions:

1. Revoke a practitioner's license, certificate or authorization.
2. Suspend a practitioner's license, certificate or authorization until further order of the board or for a specific period.
3. Prohibit permanently, until further order of the board, or for a specific period, a practitioner from engaging in specified practices, methods, or acts.
4. Require additional education or training.
5. Order a physical or mental evaluation, or order alcohol and drug screening within a time specified by the board.
6. Issue a public letter of reprimand.
7. Order any other resolution appropriate to the circumstances of the case.

282—11.34(272) Reinstatement. Any person whose license, certificate or authorization to practice has been suspended may apply to the board for reinstatement in accordance with the terms and conditions of the order of the suspension.

11.34(1) All proceedings for reinstatement shall be initiated by the respondent, who shall file with the board an application for reinstatement. Such application shall be docketed in the original case in which the license, certificate or authorization was suspended. All proceedings upon the application for reinstatement shall be subject to the same rules of procedure as other cases before the board.

11.34(2) An application for reinstatement shall allege facts which, if established, will be sufficient to enable the board to determine that the basis for the suspension of the respondent's license, certificate or authorization no longer exists and that it will be in the public interest for the license, certificate or authorization to be reinstated. The burden of proof to establish such facts shall be on the respondent.

11.34(3) An order denying or granting reinstatement shall be based upon a decision which incorporates findings of fact and conclusions of law.

282—11.35(272) Application denial and appeal. The executive director is authorized by Iowa Code section 272.7 to grant or deny applications for licensure. If the executive director denies an application for an initial or exchange license, certificate, or authorization, the executive director shall send to the applicant by regular first-class mail written notice identifying the factual and legal basis for denying the application. If the executive director denies an application to renew an existing license, certificate, or authorization, the provisions of rule 282—11.36(272) shall apply.

11.35(1) *Mandatory grounds for license denial.* The executive director shall deny an application based on the grounds set forth in Iowa Code section 272.2(14), including:

a. The license application is fraudulent.

b. The applicant's license or certification from another state is suspended or revoked.

c. The applicant fails to meet board standards for application or for license renewal.

d. The applicant is less than 21 years of age, except that a coaching authorization or paraeducator certificate may be issued to an applicant who is 18 years of age or older, as provided in Iowa Code sections 272.12 and 272.31. A student enrolled in a practitioner preparation program who meets board requirements for a temporary, limited purpose license and who is seeking to teach as part of the practicum or internship may be less than 21 years of age.

e. The applicant has been convicted of one of the disqualifying criminal convictions set forth in paragraph 11.35(2)*"a."*

11.35(2) *Conviction of a crime and founded child abuse.*

a. *Disqualifying criminal convictions.* The board shall deny an application for licensure if the applicant or licensee has been convicted, has pled guilty to, or has been found guilty of the following criminal offenses, regardless of whether the judgment of conviction or sentence was deferred:

(1) Any of the following forcible felonies included in Iowa Code section 702.11: child endangerment, assault, murder, sexual abuse, or kidnapping;

(2) Any of the following criminal sexual offenses, as provided in Iowa Code chapter 709, involving a child:

1. First-, second- or third-degree sexual abuse committed on or with a person who is under the age of 18;
2. Lascivious acts with a child;
3. Assault with intent to commit sexual abuse;
4. Indecent contact with a child;
5. Sexual exploitation by a counselor;
6. Lascivious conduct with a minor;
7. Enticing a minor under Iowa Code section 710.10; or
8. Human trafficking under Iowa Code section 710A.2;

(3) Incest involving a child as prohibited by Iowa Code section 726.2;

(4) Dissemination and exhibition of obscene material to minors as prohibited by Iowa Code section 728.2;

(5) Telephone dissemination of obscene material to minors as prohibited by Iowa Code section 728.15;

(6) Any offense specified in the laws of another jurisdiction, or any offense that may be prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in paragraph 11.35(2)*"a"*; or

(7) Any offense under prior laws of this state or another jurisdiction, or any offense under prior law that was prosecuted in a federal, military, or foreign court, that is comparable to an offense listed in paragraph 11.35(2)*"a."*

b. *Other criminal convictions and founded child abuse.* When determining whether a person should be denied licensure based on the conviction of any other crime, including a felony, or a founded report of child abuse, the executive director and the board shall consider the following:

(1) The nature and seriousness of the crime or founded abuse in relation to the position sought;

(2) The time elapsed since the crime or founded abuse was committed;

(3) The degree of rehabilitation which has taken place since the crime or founded abuse was committed;

(4) The likelihood that the person will commit the same crime or abuse again;

(5) The number of criminal convictions or founded abuses committed; and

(6) Such additional factors as may in a particular case demonstrate mitigating circumstances or heightened risk to public safety.

11.35(3) *Fraudulent applications.* An application shall be considered fraudulent pursuant to Iowa Code section 272.2(14)*"b"*(3) if it contains any false representation of a material fact or any omission of a material fact which should have been disclosed at the time of application for licensure or is submitted with a false or forged diploma, certificate, affidavit, identification, or other document material to the

applicant's qualification for licensure or material to any of the grounds for denial set forth in Iowa Code section 272.2(14).

11.35(4) *Appeal procedure.*

a. An applicant who is aggrieved by the denial of an application for licensure and who desires to challenge the decision of the executive director must appeal the decision and request a hearing before the board within 30 calendar days of the date the notice of license denial is mailed. An appeal and request for hearing must be in writing and is deemed made on the date of the United States Postal Service nonmetered postmark or the date of personal service to the board office. The request for hearing shall specify the factual or legal errors the applicant contends were made by the executive director, must identify any factual disputes upon which the applicant desires an evidentiary hearing, and may provide additional written information or documents in support of licensure. If a request for hearing is timely made, the executive director shall promptly issue a notice of contested case hearing on the grounds asserted by the applicant.

b. The board, in its discretion, may act as presiding officer at the contested case hearing, may hold the hearing before a panel of three board members, or may request that an administrative law judge act as presiding officer. The applicant may request that an administrative law judge act as presiding officer and render a proposed decision pursuant to rule 282—11.8(17A,272). A proposed decision by a panel of board members or an administrative law judge is subject to appeal or review by the board pursuant to rule 282—11.28(17A,272).

c. Hearings concerning licensure denial shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. While each party shall have the burden of establishing the affirmative of matters asserted, the applicant shall have the ultimate burden of persuasion as to the applicant's qualification for licensure.

d. On appeal, the board may grant or deny the application for licensure. If the application for licensure is denied, the board shall state the reason or reasons for the denial and may state conditions under which the application could be granted, if applicable.

11.35(5) *Judicial review.* Judicial review of a final order of the board denying licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case. In order to exhaust administrative remedies, an applicant aggrieved by the executive director's denial of an application for licensure must timely appeal the adverse decision to the board.

[**ARC 9209B**, IAB 11/3/10, effective 12/8/10; **ARC 0025C**, IAB 3/7/12, effective 4/11/12; **ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.36(272) Denial of renewal application. If the executive director denies an application to renew a license, certificate or authorization, a notice of hearing shall be issued to commence a contested case proceeding. The executive director may deny a renewal application on the same grounds as those that apply to an application for initial or exchange licensure described in subrules 11.35(1) to 11.35(3).

11.36(1) *Hearing procedure.* Hearings on denial of an application to renew a license shall be conducted according to the contested case procedural rules in this chapter. Evidence supporting the denial of the license may be presented by an assistant attorney general. The provisions of subrules 11.35(4) and 11.35(5) shall apply.

11.36(2) *Judicial review.* Judicial review of a final order of the board denying renewal of licensure may be sought in accordance with the provisions of Iowa Code section 17A.19 which are applicable to judicial review of an agency's final decision in a contested case.

11.36(3) *Impact of denial of renewal application.* Pursuant to Iowa Code section 17A.18(2), if the licensee has made timely and sufficient application for renewal, an existing license shall not expire until the last day for seeking judicial review of the board's final order denying the application or a later date fixed by order of the board or reviewing court.

11.36(4) *Timeliness of renewal application.* Within the meaning of Iowa Code section 17A.18(2), a timely and sufficient renewal application shall be:

a. Received by the board on or before the date the license is set to expire or lapse;

b. Signed by the licensee if submitted in paper form or certified as accurate if submitted electronically;

c. Fully completed; and

d. Accompanied by the proper fee. The fee shall be deemed improper if the amount is incorrect, the fee was not included with the application, or the licensee's check is unsigned or returned for insufficient funds.

282—11.37(272) Mandatory reporting of contract nonrenewal or termination or resignation based on allegations of misconduct. The board of directors of a school district or area education agency, the superintendent of a school district or the chief administrator of an area education agency, and the authorities in charge of a nonpublic school shall report to the board the nonrenewal or termination, for reasons of alleged or actual misconduct, of a person's contract executed under Iowa Code sections 279.12, 279.13, 279.15 through 279.21, 279.23, and 279.24, and the resignation of a person who holds a license, certificate, or authorization issued by the board as a result of or following an incident or allegation of misconduct that, if proven, would constitute a violation of 282—subparagraph 25.3(1)*"b"*(1), when the board or reporting official has a good-faith belief that the incident occurred or the allegation is true.

11.37(1) *Method of reporting.* The report required by this rule may be made by completion and filing of the complaint form described in subrule 11.4(2) or by the submission of a letter to the executive director of the board which includes: the full name, address, telephone number, title and signature of the reporter; the full name, address, and telephone number of the person who holds a license, certificate or authorization issued by the board; a concise statement of the circumstances under which the termination, nonrenewal, or resignation occurred; and any additional information or documentation which the reporter believes will be relevant to assessment of the report pursuant to subrule 11.37(4).

11.37(2) *Timely reporting required.* The report required by this rule shall be filed within 60 days of the date of local board action on the termination or resignation.

11.37(3) *Confidentiality of report.* Information reported to the board in accordance with this rule is privileged and confidential, and, except as provided in Iowa Code section 272.13, is not subject to discovery, subpoena, or other means of legal compulsion for its release to a person other than the respondent and the board and its employees and agents involved in licensee discipline, and is not admissible in evidence in a judicial or administrative proceeding other than the proceeding involving licensee discipline.

11.37(4) *Action upon receipt of report.*

a. Upon receipt of a report under this rule, the executive director of the board shall review the information reported to determine whether a complaint investigation should be initiated.

b. In making this determination, the executive director shall consider the nature and seriousness of the reported misconduct in relation to the position sought or held, the time elapsed since the misconduct, the degree of rehabilitation, the likelihood that the individual will commit the same misconduct again, and the number of reported incidents of misconduct.

c. If the executive director determines a complaint should not be initiated, no further formal action will be taken and the matter will be closed.

d. If the executive director determines a complaint investigation should be initiated, the executive director shall assign the matter for investigation pursuant to rule 282—11.5(272).

11.37(5) *Proceedings upon investigation.* From the time of initiation of an investigation, the matter will be processed in the same manner as a complaint filed under rule 282—11.4(17A,272).

282—11.38(256,272) Reporting by department of education employees.

11.38(1) *Method of reporting.* A report of misconduct made by the director, pursuant to Iowa Code section 256.9(52), or made by an employee of the department of education, pursuant to Iowa Code section 272.15(2), shall comply with the requirements of subrule 11.37(1).

11.38(2) *Confidentiality.* Information reported to the board in accordance with this rule is privileged and confidential, except as provided in Iowa Code section 272.13.

11.38(3) *Review and investigation of report.* The report shall be reviewed and investigated pursuant to subrules 11.37(4) and 11.37(5).
[**ARC 0026C**, IAB 3/7/12, effective 4/11/12]

282—11.39(272) Denial of application during a pending professional practices case. The executive director may deny an application for a Class B license if the applicant is currently under investigation and probable cause has been determined by the board.
[**ARC 9659B**, IAB 8/10/11, effective 9/14/11]

These rules are intended to implement Iowa Code chapters 17A and 272.

[Filed 7/12/73; amendment filed 10/6/75—published 10/20/75, effective 11/24/75]
[Filed emergency 4/2/86—published 4/23/86, effective 4/23/86]
[Filed emergency 5/25/88—published 6/15/88, effective 5/25/88]
[Filed emergency 4/26/90—published 5/16/90, effective 4/27/90]
[Filed 5/20/92, Notice 2/19/92—published 6/10/92, effective 7/15/92]
[Filed 1/12/96, Notice 10/25/95—published 1/31/96, effective 3/6/96]
[Filed 1/21/00, Notice 10/6/99—published 2/9/00, effective 3/15/00][1]
[Filed 3/16/01, Notice 1/10/01—published 4/4/01, effective 5/9/01]
[Filed 11/21/01, Notice 8/8/01—published 12/12/01, effective 1/16/02][2]
[Filed 5/23/03, Notice 12/11/02—published 6/11/03, effective 7/16/03]
[Filed 7/3/03, Notice 4/16/03—published 7/23/03, effective 8/27/03]
[Filed 7/7/03, Notice 4/16/03—published 7/23/03, effective 8/27/03]
[Filed 1/30/04, Notice 11/12/03—published 2/18/04, effective 3/24/04]
[Filed 1/28/05, Notice 11/10/04—published 2/16/05, effective 3/23/05]
[Filed 11/14/07, Notice 9/12/07—published 12/5/07, effective 1/9/08]
[Filed 2/13/08, Notice 11/7/07—published 3/12/08, effective 4/16/08]
[Filed emergency 6/25/08—published 7/16/08, effective 6/25/08]
[Filed 6/25/08, Notice 5/7/08—published 7/16/08, effective 8/20/08]
[Filed ARC 8406B (Notice ARC 8143B, IAB 9/9/09), IAB 12/16/09, effective 1/20/10][3]
[Editorial change: IAC Supplement 1/27/10]
[Filed Emergency ARC 8823B, IAB 6/2/10, effective 5/14/10]
[Filed ARC 9209B (Notice ARC 8971B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9659B (Notice ARC 9450B, IAB 4/6/11), IAB 8/10/11, effective 9/14/11]
[Filed ARC 0025C (Notice ARC 9923B, IAB 12/14/11), IAB 3/7/12, effective 4/11/12]
[Filed ARC 0026C (Notice ARC 9924B, IAB 12/14/11), IAB 3/7/12, effective 4/11/12]
[Filed ARC 0606C (Notice ARC 0494C, IAB 12/12/12), IAB 2/20/13, effective 3/27/13]
[Filed ARC 0853C (Notice ARC 0677C, IAB 4/3/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 1455C (Notice ARC 1344C, IAB 2/19/14), IAB 5/14/14, effective 6/18/14]
[Filed ARC 1543C (Notice ARC 1378C, IAB 3/19/14), IAB 7/23/14, effective 8/27/14]
[Filed ARC 3196C (Notice ARC 3012C, IAB 4/12/17), IAB 7/5/17, effective 8/9/17]

[1] Effective date of 282—Ch 11 delayed 45 days by the Administrative Rules Review Committee at its meeting held March 10, 2000; delay lifted by the Committee at its meeting held April 7, 2000, effective April 8, 2000.

[2] Two ARCs

[3] Effective date of ARC 8406B delayed until the adjournment of the 2010 Session of the General Assembly by the Administrative Rules Review Committee at its meeting held January 5, 2010.

CHAPTER 12
FEES

282—12.1(272) Issuance of licenses, certificates, authorizations, and statements of professional recognition. All application and licensure fees are nonrefundable. The fee for the issuance of a license, certificate, statement of professional recognition, or authorization shall be $85 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; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter]

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; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter]

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.

[**ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter]

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; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter]

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 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; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

282—12.7(272) Fees nonrefundable. All fees as set out in this chapter are nonrefundable.

282—12.8(272) Portfolio review and evaluation fee. For the professional education core, the portfolio review and evaluation fee shall be $500.

[**ARC 8606B**, IAB 3/10/10, effective 4/14/10; **ARC 2229C**, IAB 11/11/15, effective 12/16/15; see Delay note at end of chapter and Nullification note at end of chapter; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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]
[Filed ARC 9386B (Notice ARC 9203B, IAB 11/3/10), IAB 2/23/11, effective 3/30/11]
[Filed ARC 9743B (Notice ARC 9570B, IAB 6/29/11), IAB 9/7/11, effective 10/12/11]
[Filed ARC 2017C (Notice ARC 1919C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]
[Filed ARC 2229C (Notice ARC 2131C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15][1,2]

[Filed ARC 3196C (Notice ARC 3012C, IAB 4/12/17), IAB 7/5/17, effective 8/9/17]

[1] December 16, 2015, effective date of ARC 2229C [12.1 to 12.6, 12.8] delayed until the adjournment of the 2016 General Assembly by the Administrative Rules Review Committee at its meeting held December 8, 2015.

[2] See SJR 2007 of the 2016 Session of the Eighty-sixth General Assembly regarding nullification of the amendments to 12.1 to 12.6 and 12.8 (ARC 2229C, IAB 11/11/15). Prior language restored IAC Supplement 4/27/16.

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.

13.1(1) *Licenses, authorizations, certificates, and statements of professional recognition.* Licenses, authorizations, certificates, and statements of professional recognition are issued upon application filed on a form provided by the board of educational examiners and upon completion of the following:

a. *National criminal history background check.* An initial applicant will be required to submit a completed fingerprint packet that accompanies the application to facilitate a national criminal history background check. The fee for the evaluation of the fingerprint packet will be assessed to the applicant.

b. *Iowa division of criminal investigation background check.* An Iowa division of criminal investigation (DCI) background check will be conducted on initial applicants. The fee for the evaluation of the DCI background check will be assessed to the applicant.

c. *Registries and records check.* A check of the following registries and records will be conducted on initial applicants: the sex offender registry under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, the central registry for dependent adult abuse information maintained under Iowa Code chapter 235B, and the information in the Iowa court information system available to the general public. The fee for checks of these registries and records will be assessed to the applicant.

13.1(2) *Temporary permits.* The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; determination that the applicant meets all applicable prerequisites for issuance of the license, certification, or authorization; and satisfactory evaluation of the Iowa criminal history background check. The temporary permit shall serve as evidence of the applicant's authorization to hold a position in Iowa schools, pending the satisfactory completion of the national criminal history background check. The temporary permit shall expire upon issuance of the requested license, 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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15]

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, and the applicant has verified fewer than three years of valid out-of-state teaching experience. If the teacher preparation program was completed prior to January 1, 2013, or if the applicant has verified three years of valid out-of-state teaching experience, 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. Applicants seeking a board of educational examiners transcript review must have achieved a C- grade or higher in the courses that will be considered for licensure.

(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; **ARC 2584C**, IAB 6/22/16, effective 7/27/16]

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 within the applicant's approved endorsement area(s). In lieu of completion of an Iowa state-approved mentoring and induction program, the applicant must provide evidence of three years' successful teaching experience within the applicant's approved endorsement area(s) at any of the following:

- An accredited nonpublic school in this state.
- A preschool program approved by the United States Department of Health and Human Services.
- Preschool programs at school districts approved to participate in the preschool program under Iowa Code chapter 256C.
- Shared visions programs receiving grants from the child development coordinating council under Iowa Code section 256A.3.
- Preschool programs receiving moneys from the school ready children grants account of the early childhood Iowa fund created in Iowa Code section 256I.11.
- An out-of-state PK-12 educational setting.

[**ARC 2016C**, IAB 6/10/15, effective 7/15/15; **ARC 2792C**, IAB 11/9/16, effective 12/14/16]

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 two-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; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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. Applicants for this endorsement must also hold the teacher—elementary classroom endorsement set forth in subrule 13.26(4) or the early childhood special education endorsement set forth in 282—subrule 14.2(1).

b. Content. Coursework must total a minimum of 18 semester hours and shall include the following:

(1) Child development and learning to include young children's characteristics and needs, with an emphasis on cognitive, language, physical, social, and emotional development, both typical and

atypical, the multiple interacting influences on early development, and the creation of environments that are healthy, respectful, supportive, and challenging for each and every child.

(2) Building family and community relationships to include understanding that successful early childhood education depends upon reciprocal and respectful partnerships with families, communities, and agencies, that these partnerships have complex and diverse characteristics, and that all families should be involved in their children's development and learning.

(3) Assessment in early childhood to include child observation, documentation, and data collection, the development of appropriate goals, the benefits and uses of assessment for curriculum and instructional strategies, the use of technology when appropriate for assessment and adaptations, and building assessment partnerships with families to positively influence the development of each child.

(4) Developmentally effective approaches to include understanding how positive relationships and supportive interactions are the foundation of working with young children and families; knowing and understanding a wide array of developmentally appropriate approaches, including play and creativity, instructional strategies, and tools to connect with children and families; and reflecting on the teacher's own practice to promote positive outcomes for each child.

(5) Content knowledge to build a meaningful curriculum through the use of academic disciplines, including language and literacy, the arts (music, drama, dance, and visual arts), mathematics, science, social studies, physical activity, and health, for designing, implementing, and evaluating inquiry-based experiences that promote positive development and learning for each child.

(6) Collaboration and professionalism to include involvement in the early childhood field, knowledge about ethical and early childhood professional standards, engagement in continuous collaborative learning to inform practice, reflective and critical perspectives on early childhood education, and informed advocacy for young children and the profession.

(7) Field experiences and opportunities to observe and practice in a variety of early childhood settings, which include, at a minimum, 40 hours of observation and practice in a variety of preschool settings such as urban, rural, socioeconomic status, cultural diversity, program types, and program sponsorship.

(8) Historical, philosophical, and social foundations of early childhood education.

(9) Student teaching in a prekindergarten setting as required in rule 281—79.14(256).

13.26(2) *Teacher—birth through grade three, inclusive settings.*

a. Authorization. The holder of this endorsement is authorized to teach children from birth through grade three in inclusive settings.

b. Content.

(1) Promoting child development and learning and individual learning differences.

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, mental health, aesthetics, and adaptive behavior and how these impact development and learning in the first years of life, including the etiology, characteristics, and classifications of common disabilities in infants and young children and specific implications for development and learning.

2. Recognize that children are best understood in the contexts of family, culture and society and that cultural and linguistic diversity, stress, risk factors, biological and environmental factors, family strengths, and trauma influence development and learning at all stages, including pre-, peri-, and postnatal development and learning. Communicate the importance of responsive care to a child's development of identity and sense of self.

3. Use developmental knowledge to create learning environments and classroom procedures that promote positive social interaction, active engagement, high expectations for learning, mutual respect, and self-regulation through individually appropriate expectations and positive guidance techniques for each child to meet the child's optimum potential regardless of proficiency. Implement and evaluate preventative and reductive strategies to address challenging behaviors. Use motivational and instructional interventions to teach individuals with exceptionalities how to adapt to different environments. Know how to intervene safely and appropriately with individuals in crisis.

4. Use both child-initiated and teacher-facilitated instructional methods, including strategies such as small and large group projects, play, systematic instruction, group discussion and cooperative decision making. Organize space, time, materials, peers, and adults to maximize progress in natural and structured environments. Embed learning opportunities in everyday routines, relationships, activities, and places. Understand the impact of social and physical environments on development and learning.

5. Engage in intentional practices and implement learning experiences that value diversity and demonstrate understanding that bias and discrimination impact development. Understand how language, culture, and family background influence and support the learning of each child.

(2) Building family and community relationships.

1. Build family and community relationships to include understanding that successful early childhood education depends upon reciprocal and respectful partnerships with families, communities, and agencies, that these partnerships have complex and diverse characteristics, and that all families should be involved in their children's development and learning.

2. Understand diverse family and community characteristics and how language, culture, and family background influence and support children's learning, and apply that knowledge to develop, implement, and evaluate learning experience and strategies that respect and reflect the diversity of children and their families.

3. Understand how to apply theories and knowledge of dynamic roles and relationships within and between families, schools, and communities. Recognize how to adapt consistently to the expressed and observed strengths and needs of the family, including two-way communication, and how to support families' choices and priorities in the development of goals and intervention strategies.

4. Understand how to coordinate with all (caregivers, professionals, and agencies) who provide care and learning opportunities for each child by developing a community of support for children and families through interagency collaboration to include agreements, referrals, and consultation.

(3) Observing, documenting, and assessing to support young children and families.

1. Use technically sound formal and informal assessments that minimize bias and evaluation results to adapt and guide instruction. Demonstrate a range of appropriate assessment and evaluation strategies (e.g., family interview, observation, documentation, assessment instrument) to support individual strengths, interests, and needs.

2. Design curricula, assessments, and teaching and intervention strategies that align with learner and program goals, including the development of individualized family service plans (IFSPs) and individualized education plans (IEPs). Assist families in identifying resources, priorities, and concerns in relation to the child's development. Understand and utilize assessment partnerships with families and with professional colleagues to build effective learning environments. Understand the role of the families in the assessment process and support the choices they make (e.g., observer, participant). Participate as a team member to integrate assessment results in the development and implementation of individualized plans.

3. Understand and utilize observation, documentation, and other appropriate assessment tools and approaches, including the use of technology in documentation, assessment and data collection. Implement authentic assessment based on observation of spontaneous play. Demonstrate knowledge of alignment of assessment with curriculum, content standards, and local, state, and federal requirements. Assess progress in the developmental domains, play, and temperament.

4. Understand and utilize responsible assessments to promote positive outcomes for each child, including the use of assistive technology for children with disabilities. Use a variety of materials and contexts to maintain the interest of infants and young children in the assessment process.

5. Implement current educational, legal, and ethical guidelines when using assessment practices to support children's individual strengths, interests, and needs (e.g., cultural, linguistic, ability diversity).

(4) Using developmentally and individually effective approaches to connect with children and families.

1. Understand positive relationships and supportive interactions as the foundation of the teacher's work with young children. Reflect on the teacher's own practice to promote positive outcomes for each child and family.

2. Develop, implement, and evaluate individualized plans, including IFSPs and IEPs, as a team leader with families and other professionals. Demonstrate appropriate and effective supports for children and families transitioning into and out of programs or classrooms. Seek and use additional resources and agencies outside the program/school when needed to effectively facilitate the learning and social/emotional development of each child.

3. Plan, develop, implement, and evaluate integrated learning experiences for home-, center- and school-based environments for infants, toddlers, preprimary and primary children, their families, and other care providers based on knowledge of individual children, the family, and the community. Select, develop, and evaluate developmentally and functionally appropriate materials, equipment, and environments. Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs. Use a broad repertoire of developmentally and individually appropriate teaching/learning approaches and effective strategies and tools for early education, including appropriate uses of technology. Facilitate child-initiated development and learning.

4. Consider an individual's abilities, interests, learning environments, and cultural and linguistic factors in the selection, development, and adaptation of learning experiences for individuals with exceptionalities. Use teacher-scaffolded and -initiated instruction to complement child-initiated learning. Link development, learning experiences, and instruction to promote educational transitions. Use individual and group guidance and problem-solving techniques to develop supportive relationships with and among children. Use strategies to teach social skills and conflict resolution.

5. Implement basic health, nutrition, and safety management procedures, including the design of physically and psychologically safe and healthy indoor and outdoor environments to promote development and learning. Recognize signs of emotional distress, physical and mental abuse and neglect in young children and understand mandatory reporting procedures. Demonstrate proficiency in infant-child cardiopulmonary resuscitation, emergency procedures and first aid.

6. 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, evaluation of staff, and continuing improvement of programs and services. Employ adult learning principles in consulting with and training family members and service providers.

7. Demonstrate the ability to collaborate with general educators and other colleagues to create safe, inclusive, culturally responsive learning environments to engage individuals with exceptionalities and diverse abilities in meaningful learning activities and social interactions.

(5) Using content knowledge to build a meaningful curriculum.

1. Develop and implement appropriate current research-supported learning experiences with a focus on the developmental domains, play, temperament, language and literacy to include first (home) and second language acquisition, mathematics, science, the arts (music, visual art, and drama), physical activity, health and safety, social studies, social skills, higher-thinking skills, and developmentally and individually appropriate methodology. Methods courses are required for the following areas: literacy, mathematics, social studies, science, physical education and wellness, and visual and performing arts.

2. Use the Iowa Early Learning Standards and the Iowa core with information from ongoing child observations and assessments to plan, implement, and evaluate appropriate instruction that improves academic and developmental progress of each child, including those with IFSPs/IEPs.

3. Understand the central concepts, structures of the discipline, and tools of inquiry of content areas taught, and demonstrate the ability to organize this knowledge, integrate cross-disciplinary skills, and develop meaningful learning progressions for individuals with exceptionalities (diverse abilities).

4. Modify general and specialized curricula to make them accessible to individuals with exceptionalities (diverse abilities). Develop adaptations and accommodations for infants, toddlers, preprimary, and primary children to meet their individual needs.

(6) Professional responsibilities.

1. Demonstrate awareness of early childhood program criteria, including the following: National Association for the Education of Young Children (NAEYC), Iowa Early Learning Standards, Head Start Performance Standards, and Iowa Quality Preschool Program Standards (IQPPS).

2. Collaborate with supervisors, mentors, and colleagues to enhance professional growth within and across disciplines to inform practice, including the use of data for decision making, and understand how to design and implement a professional development plan based on student achievement, self, peer, and supervisory evaluations and recommended practices.

3. Understand the significance of lifelong learning and participate in professional activities and learning communities. Participate in activities of professional organizations relevant to early childhood regular education, special education, and early intervention.

4. Use relevant national and state professional guidelines (national, state, or local), state curriculum standards, and current trends for content and outcomes and to inform and improve practices for young children and their families.

5. Adhere to state and national professional and ethical principles, practices, and codes.

6. Advocate for developmentally and individually appropriate practice, demonstrate awareness of issues that affect the lives of each child, and demonstrate necessary communication skills.

7. Understand historical, philosophical and foundational knowledge and how current issues and the legal bases of services influence professional practice in early childhood, early intervention, early childhood special education, and general and regular education in the K-3 age groups. Understand trends and issues in early childhood education, early childhood special education, and early intervention.

8. Provide guidance and direction to paraeducators, tutors, and volunteers.

(7) Early childhood field experiences.

1. Pre-student teaching field experiences, which must comprise a minimum of 100 clock hours, to include at least 20 hours of working with each age group (infants and toddlers, preprimary, and primary).

2. Experiences working in at least three settings that offer early childhood education, such as approved child care centers and registered child development homes, school-based preschool, community agencies, or home visiting programs.

3. Experiences working with children who have a range of abilities and disabilities and who reflect diverse family systems and other differentiating factors, such as urban and rural, socioeconomic status, and cultural and linguistic diversity.

4. Completion of supervised student teaching experience in at least two different settings including registered child development homes, home visiting programs, state-accredited child care centers, or classrooms which include both children with and without disabilities in two of three age levels: infant and toddler, preprimary, and primary.

13.26(3) *Teacher—prekindergarten through grade three, including special education.* Rescinded IAB 7/5/17, effective 8/9/17.

13.26(4) *Teacher—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 development, which must include:

1. Content:

- Oral and written communication development; and linguistics, including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics, and the relationship of these components to typical and atypical reading development and reading instruction;
- Phonemic awareness;
- Word identification, including phonics and orthography;
- Fluency;
- Vocabulary;
- Comprehension;
- Writing mechanics;
- Writing conventions;

- Writing process;
- Children's literature.

2. Methods:

- Assessment, diagnosis and evaluation of student learning in literacy, including the knowledge of the signs and symptoms of dyslexia and other reading difficulties;
- 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 strategies and instructional technology for designing and delivering effective instruction, including appropriate interventions, groupings, remediation, assistive technology, and classroom accommodations for all students including students with dyslexia and other difficulties;
- 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.

(9) Student teaching in an elementary general education classroom.

[**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; **ARC 2527C**, IAB 5/11/16, effective 6/15/16; **ARC 2584C**, IAB 6/22/16, effective 7/27/16; **ARC 3197C**, IAB 7/5/17, effective 8/9/17]

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.* K-8 and 5-12. Completion of 24 semester hours in reading to include all of the following requirements:

a. *Foundations of reading.* This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of the psychological, sociocultural, motivational, 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 the analysis of 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 and also definitions of reading difficulties including but not limited to dyslexia.

(3) The practitioner demonstrates knowledge of the major components of reading, such as comprehension, vocabulary, word identification, fluency, phonics, and phonemic awareness, and effectively integrates curricular standards with student interests, motivation, and background knowledge.

b. Reading curriculum and instruction. This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of designing and implementing an integrated, comprehensive, and balanced curriculum that addresses the major components of reading and contains a wide range of texts, including but not limited to narrative, expository, and poetry, and including traditional print, digital, and online resources.

(2) The practitioner uses knowledge of a range of research-based strategies and instructional technology for designing and delivering effective instruction, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties.

(3) The practitioner demonstrates knowledge of grouping students, selecting materials appropriate for learners with diverse abilities at various stages of reading and writing development, differentiating instruction to meet the unique needs of all learners, including students with dyslexia, offering sufficient opportunities for students to practice reading skills, and providing frequent and specific instructional feedback to guide students' learning.

(4) The practitioner demonstrates knowledge of designing instruction to meet the needs of diverse populations, including populations in urban, suburban, and rural settings, as well as for students from various cultural and linguistic backgrounds.

(5) The practitioner demonstrates knowledge of creating a literate physical environment which is low risk, supports students as agents of their own learning, and supports a positive socio-emotional impact for students to identify as readers.

c. Reading assessment, diagnosis and evaluation. This requirement includes the following competencies:

(1) The practitioner understands types of reading and writing assessments and their purposes, strengths, and limitations.

(2) The practitioner demonstrates knowledge of selecting and developing appropriate assessment instruments, procedures, and practices that range from individual to group and from formal to informal to alternative for the identification, screening, and diagnosis of all students' reading proficiencies and needs including knowledge of the signs and symptoms of dyslexia and other reading difficulties.

(3) The practitioner demonstrates knowledge of assessment data analysis to inform, plan, measure, progress monitor, and revise instruction for all students and to communicate the outcomes of ongoing assessments to all stakeholders.

(4) The practitioner demonstrates awareness of policies and procedures related to special programs, including Title I.

d. Reading in the content areas. This requirement includes the following competencies:

(1) The practitioner demonstrates knowledge of morphology and the etymology of words, along with text structure and the dimensions of content area vocabulary and comprehension, including literal, interpretive, critical, and evaluative.

(2) The practitioner demonstrates an understanding of reading theory, reading knowledge, and a variety of research-based strategies and approaches to provide effective literacy instruction into content areas.

(3) The practitioner demonstrates knowledge of integrating literacy instruction into content areas for all students, including but not limited to students with disabilities, students who are at risk of academic

failure, students who have been identified as gifted and talented, students who have limited English language proficiency, and students with dyslexia, whether or not such students have been identified as children requiring special education under Iowa Code chapter 256B.

e. Language development. This requirement includes the following competency: The practitioner uses knowledge of oral language development, linguistics including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics and the relationship of these components to typical and atypical reading development and reading instruction, cognitive academic language development, oral and written language proficiency (including second language development), acquisition of reading skills, and the variations related to cultural and linguistic diversity to provide effective instruction in reading and writing.

f. Oral communication instruction. 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 language for academic purposes by all learners.

g. Written communication instruction. This requirement includes the following competency: The practitioner uses knowledge of reading-writing-speaking connections; the writing process to include structures of language and grammar; 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.

h. Children's fiction and nonfiction (K-8 only) or adolescent or young adult fiction and nonfiction (5-12 only). This requirement includes the following competency: The practitioner uses knowledge of children's literature (K-8) or adolescent or young adult literature (5-12) 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.

i. Practicum. This requirement includes the following competencies:

(1) The practitioner works with appropriately 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.

13.28(16) *Reading specialist.* K-12. The applicant must have met the requirements for the standard license and a K-8 or 5-12 reading endorsement and must present evidence of at least three years 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 24 semester hours to include the following:

(1) Foundations of reading. The reading specialist will understand the historical, theoretical, and evidence-based foundations of reading and writing processes and instruction and will be able to interpret these findings to model exemplary instructional methods for students with typical and atypical literacy development and effectively develop and lead professional development.

(2) Curriculum and instruction. The reading specialist will use instructional approaches, materials, and an integrated, comprehensive, balanced curriculum to support student learning in reading and writing including the following:

1. Work collaboratively with teachers to develop a literacy curriculum that has vertical and horizontal alignment K-12 and that uses instructional approaches supported by literature and research for the following areas: print, phonemic awareness, phonics, fluency, comprehension, vocabulary, writing, critical thinking, and motivation.

2. Support classroom teachers to implement and adapt in-depth instructional approaches, including but not limited to approaches to improve decoding, comprehension, and information retention, to meet the language-proficiency needs of English language learners and the needs of students with reading difficulties or reading disabilities, including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties within or outside the regular classroom.

3. Demonstrate a knowledge of a wide variety of quality traditional print, digital, and online resources and support classroom teachers in building and using a quality, accessible classroom library and materials collection that meets the specific needs and abilities of all learners.

4. Provide support for curriculum and instruction through modeling, coteaching, observing, planning, reviewing literacy data, and providing resources.

(3) Assessment, diagnosis, and evaluation. The reading specialist will use a variety of assessment tools and practices to plan and evaluate effective reading and writing instruction including the following:

1. Demonstrate an understanding of the literature and research related to assessments and their purposes, including the strengths and limitations of assessments, and assessment tools for screening, diagnosis, progress monitoring, and measuring outcomes; demonstrate an understanding of the signs and symptoms of reading difficulties including but not limited to dyslexia; and also demonstrate an understanding of district and state assessments, proficiency standards and student benchmarks.

2. Select, administer, and interpret assessments for specific purposes, including collaboration with teachers in the analysis of data, and leading schoolwide or districtwide scale analyses to select assessment tools that provide a systemic framework for assessing reading, writing, and language growth of all students, including those with reading difficulties and reading disabilities including but not limited to students with dyslexia and English language learners.

3. Use assessment information to plan and evaluate instruction, including multiple data sources for analysis and instructional planning, for examining the effectiveness of specific intervention practices and students' responses to interventions including appropriate interventions, remediation, assistive technology, and classroom accommodations for students with dyslexia and other difficulties, and to plan professional development initiatives.

4. Communicate assessment results and implications to a variety of audiences.

(4) Administration and supervision of reading programs. The reading specialist will:

1. Demonstrate foundational knowledge of adult learning theories and related research about organizational change, professional development, and school culture.

2. Demonstrate the practical application of literacy leadership including planning, developing, supervising, and evaluating literacy programs at all levels.

3. Demonstrate knowledge of supervising an overall reading program, including but not limited to staffing; budgetary practices; planning, preparing, and selecting materials; subsystems; special provisions; and evaluating teacher performance.

4. Participate in, design, facilitate, lead, and evaluate effective and differentiated professional development programs to effectively implement literacy instruction.

5. Demonstrate an understanding of local, state, and national policies that affect reading and writing instruction.

6. Promote effective communication and collaboration among stakeholders, including parents and guardians, teachers, administrators, policymakers, and community members, and advocate for change when necessary to promote effective literacy instruction.

(5) Educational research, measurement and evaluation. The reading specialist will effectively utilize existing research and learn to conduct new research to continuously improve the design and implementation of a comprehensive reading system.

(6) Psychology of language and reading. The reading specialist will understand the highly complex processes by which children learn to speak, read, and write, including language acquisition, linguistics including phonology and phonological awareness, sound-symbol association, syllable types, morphology, syntax and semantics and the relationship of these components to typical and atypical reading development and reading instruction, ranges of individual differences, reading difficulties and reading disabilities, including but not limited to dyslexia, and the importance of the role of diversity in learning to read and write.

(7) Practicum in reading leadership. The reading specialist will participate in elementary and secondary practicum experiences with licensed teachers who are serving in leadership roles in the area of reading.

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 candidate will complete a preservice supervised practicum of a minimum of 100 hours, and at least 40 of these hours must be direct service. Candidates will complete a supervised internship for a minimum of 600 hours, and at least 240 of these hours must be direct service. For candidates seeking both the K-8 and 5-12 professional school counselor endorsements, a minimum of 100 hours of the practicum or internship experiences listed above must be completed at each of the desired endorsement levels.

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 candidate will complete a preservice supervised practicum and an internship that meet the requirements set forth in 13.28(26)*"c"*(12).

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, and

(6) A current certificate of CPR training.

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.*

a. Completion of any 5-12 endorsement and, in addition thereto, coursework in foundations of career and technical education and coordination of cooperative programs, and work experience which meets one of the following:

(1) Four thousand hours of career and technical experience in two or more careers; or

(2) One thousand hours of work experience or externships in two or more careers and two or more years of teaching experience at the PK-12 level.

b. The multioccupations endorsement also authorizes the holder to supervise students in cooperative programs, work-based learning programs, and similar programs in which the student is placed in school-sponsored, on-the-job situations.

13.28(34) *CTE information technology.* 5-12.

a. *Authorization.* The holder of this endorsement is authorized to teach career and technical education (CTE) information technology, CTE computer science, and CTE computer programming courses.

b. *Program requirements.* Applicants must hold a valid Iowa teaching license with at least one other teaching endorsement.

c. *Content.* A minimum of 12 semester hours of computer science to include coursework in the following:

(1) Data representation and abstraction to include primitive data types, static and dynamic data structures, and data types and stores.

(2) Designing, developing, testing and refining algorithms to include proficiency in two or more programming paradigms.

(3) Systems and networks to include operating systems, networks, mobile devices, and machine-level data representation.

d. *Methods course.* A content area methods course is required pursuant to 13.29(1). The course should include the following effective teaching and learning strategies for information technology:

(1) Curriculum development including recognizing and defining real-world computational problems; computing concepts and constructs; developing and using abstractions; creating, testing, and refining computational artifacts; and problem-solving strategies in computer science.

(2) Project-based methodologies that support active and authentic learning, fostering an inclusive computing culture, collaborative groupings, and opportunities for creative and innovative thinking.

(3) Communication about computing including multiple forms of media.

(4) Digital citizenship including the social, legal, ethical, safe and effective use of computer hardware, software, peripherals, and networks.

e. *CTE methods.*

(1) A minimum of six semester hours of career and technical curriculum and methods to include:

1. Foundations of career and technical education.
2. Methods of career and technical education.
3. Evaluation and assessment of career and technical programs.

(2) The CTE methods coursework is not required if the educator holds another career and technical endorsement.

f. *Waiver of coursework requirements.* During the first year of implementation, the coursework requirements may be waived if the practitioner demonstrates relevant content knowledge mastery and successful teaching experience in this endorsement area through criteria established by the board of educational examiners.

[**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; **ARC 2397C**, IAB 2/17/16, effective 3/23/16; **ARC 2586C**, IAB 6/22/16, effective 7/27/16; **ARC 2793C**, IAB 11/9/16, effective 12/14/16; see Delay note at end of chapter; **ARC 3197C**, IAB 7/5/17, effective 8/9/17]

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 and grade levels of the endorsement added.

(2) Practitioners who are adding a K-8 endorsement and have not student taught at the elementary level shall complete a teaching practicum in an elementary setting. Applicants seeking the early childhood or elementary endorsements set forth in rule 282—13.26(272) must complete the required field experience and teaching practicum specific to the endorsement desired.

(3) Practitioners who are adding a 5-12 endorsement and have not student taught at the secondary level shall complete a teaching practicum in a high school setting.

(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.

(5) Applicants seeking a board of educational examiners transcript review must have achieved a C- grade or higher in the courses that will be considered for an 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; **ARC 2584C**, IAB 6/22/16, effective 7/27/16]

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.

Filed 12/23/08, Notice 10/8/08—published 1/14/09, effective 2/18/09]

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

[Filed ARC 7869B (Notice ARC 7600B, IAB 2/25/09), IAB 6/17/09, effective 7/22/09]

[Filed ARC 7987B (Notice ARC 7751B, IAB 5/6/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 7986B (Notice ARC 7744B, IAB 5/6/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 8133B (Notice ARC 7778B, IAB 5/20/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8134B (Notice ARC 7860B, IAB 6/17/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8138B (Notice ARC 7871B, IAB 6/17/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8139B (Notice ARC 7872B, IAB 6/17/09), IAB 9/9/09, effective 10/14/09]
[Filed Emergency ARC 8248B, IAB 11/4/09, effective 10/12/09]
[Filed ARC 8400B (Notice ARC 8125B, IAB 9/9/09), IAB 12/16/09, effective 1/20/10]
[Filed ARC 8401B (Notice ARC 8121B, IAB 9/9/09), IAB 12/16/09, effective 1/20/10]
[Filed ARC 8402B (Notice ARC 8126B, IAB 9/9/09), IAB 12/16/09, effective 1/20/10]
[Filed ARC 8403B (Notice ARC 8129B, IAB 9/9/09), IAB 12/16/09, effective 1/20/10]
[Filed ARC 8604B (Notice ARC 8250B, IAB 11/4/09), IAB 3/10/10, effective 4/14/10]
[Filed ARC 8610B (Notice ARC 8249B, IAB 11/4/09), IAB 3/10/10, effective 4/14/10]
[Filed ARC 8607B (Notice ARC 8408B, IAB 12/16/09), IAB 3/10/10, effective 4/14/10]
[Filed ARC 8688B (Notice ARC 8436B, IAB 1/13/10), IAB 4/7/10, effective 5/12/10]
[Filed ARC 8957B (Notice ARC 8686B, IAB 4/7/10), IAB 7/28/10, effective 9/1/10]
[Filed ARC 9072B (Notice ARC 8822B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]
[Filed ARC 9070B (Notice ARC 8824B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]
[Filed ARC 9071B (Notice ARC 8825B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]
[Filed ARC 9207B (Notice ARC 8969B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9205B (Notice ARC 8961B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9206B (Notice ARC 8968B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9210B (Notice ARC 8965B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9211B (Notice ARC 8966B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9212B (Notice ARC 8967B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 9573B (Notice ARC 9382B, IAB 2/23/11), IAB 6/29/11, effective 8/3/11]
[Filed ARC 9838B (Notice ARC 9663B, IAB 8/10/11), IAB 11/2/11, effective 12/7/11]
[Filed ARC 9839B (Notice ARC 9662B, IAB 8/10/11), IAB 11/2/11, effective 12/7/11]
[Filed ARC 9840B (Notice ARC 9661B, IAB 8/10/11), IAB 11/2/11, effective 12/7/11]
[Filed ARC 9925B (Notice ARC 9744B, IAB 9/7/11), IAB 12/14/11, effective 1/18/12]
[Filed ARC 0026C (Notice ARC 9924B, IAB 12/14/11), IAB 3/7/12, effective 4/11/12]
[Filed ARC 0446C (Notice ARC 0236C, IAB 7/25/12), IAB 11/14/12, effective 12/19/12]
[Filed ARC 0448C (Notice ARC 0235C, IAB 7/25/12), IAB 11/14/12, effective 12/19/12]
[Filed ARC 0449C (Notice ARC 0312C, IAB 9/5/12), IAB 11/14/12, effective 12/19/12]
[Filed Emergency After Notice ARC 0563C, IAB 1/23/13, effective 1/1/13]
[Filed ARC 0605C (Notice ARC 0509C, IAB 12/12/12), IAB 2/20/13, effective 3/27/13]
[Filed ARC 0698C (Notice ARC 0614C, IAB 2/20/13), IAB 5/1/13, effective 6/5/13]
[Filed ARC 0865C (Notice ARC 0676C, IAB 4/3/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0866C (Notice ARC 0696C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0867C (Notice ARC 0706C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0868C (Notice ARC 0705C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0875C (Notice ARC 0700C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0986C (Notice ARC 0762C, IAB 5/29/13), IAB 9/4/13, effective 10/9/13]
[Filed ARC 1085C (Notice ARC 0879C, IAB 7/24/13), IAB 10/16/13, effective 11/20/13]
[Filed ARC 1166C (Notice ARC 0880C, IAB 7/24/13), IAB 11/13/13, effective 12/18/13]
[Filed ARC 1168C (Notice ARC 0987C, IAB 9/4/13), IAB 11/13/13, effective 12/18/13]
[Filed ARC 1171C (Notice ARC 0993C, IAB 9/4/13), IAB 11/13/13, effective 12/18/13]
[Filed ARC 1324C (Notice ARC 1182C, IAB 11/13/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 1323C (Notice ARC 1181C, IAB 11/13/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 1328C (Notice ARC 1236C, IAB 12/11/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 1327C (Notice ARC 1235C, IAB 12/11/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 1374C (Notice ARC 1272C, IAB 1/8/14), IAB 3/19/14, effective 4/23/14]

[Filed ARC 1454C (Notice ARC 1343C, IAB 2/19/14), IAB 5/14/14, effective 6/18/14]
[Filed ARC 1878C (Notice ARC 1723C, IAB 11/12/14), IAB 2/18/15, effective 3/25/15]
[Filed ARC 2015C (Notice ARC 1917C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]
[Filed ARC 2016C (Notice ARC 1918C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]
[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]
[Filed ARC 2397C (Notice ARC 2237C, IAB 11/11/15), IAB 2/17/16, effective 3/23/16]
[Filed ARC 2527C (Notice ARC 2412C, IAB 2/17/16), IAB 5/11/16, effective 6/15/16]
[Filed ARC 2584C (Notice ARC 2453C, IAB 3/16/16), IAB 6/22/16, effective 7/27/16]
[Filed ARC 2586C (Notice ARC 2450C, IAB 3/16/16), IAB 6/22/16, effective 7/27/16]
[Filed ARC 2792C (Notice ARC 2689C, IAB 8/31/16), IAB 11/9/16, effective 12/14/16]
[Filed ARC 2793C (Notice ARC 2690C, IAB 8/31/16), IAB 11/9/16, effective 12/14/16][1]
[Filed ARC 3196C (Notice ARC 3012C, IAB 4/12/17), IAB 7/5/17, effective 8/9/17]
[Filed ARC 3197C (Notice ARC 3047C, IAB 5/10/17), IAB 7/5/17, effective 8/9/17]

[1] December 14, 2016, effective date of 13.28(29)*"b"*(6) [ARC 2793C, Item 1] delayed until the adjournment of the 2017 General Assembly by the Administrative Rules Review Committee at its meeting held December 13, 2016.

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.

18.1(1) *Administrator licenses.* Administrator licenses are issued upon application filed on a form provided by the board of educational examiners and upon completion of the background check requirements set forth in rule 282—13.1(272).

18.1(2) *Temporary permits.* The executive director may issue a temporary permit to an applicant for any type of license, certification, or authorization issued by the board, after receipt of a fully completed application; 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 2230C**, IAB 11/11/15, effective 12/16/15; **ARC 2631C**, IAB 7/20/16, effective 8/24/16]

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 or has six years of professional service and administrative experience provided that at least two years are professional service experience; 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)*"a"* 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; **ARC 2631C**, IAB 7/20/16, effective 8/24/16; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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)*"a"* 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; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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, the applicant must meet the experience requirement set forth in subparagraph 18.9(1)*"c"*(1).

b. Superintendent endorsement. For the superintendent endorsement, the applicant must meet the experience requirement set forth in subrule 18.10(3).

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; **ARC 2631C**, IAB 7/20/16, effective 8/24/16]

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 or have had six years of teaching and administrative experience while holding a valid license, provided that at least two years are teaching experience.

(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 coursework requirements for an Iowa teaching license in addition to the experience requirements.

18.9(2) *PK-8 principal—out-of-state applicants.* Rescinded IAB 7/20/16, effective 8/24/16.

18.9(3) *5-12 principal—out-of-state applicants.* Rescinded IAB 7/20/16, effective 8/24/16.

[**ARC 0872C**, IAB 7/24/13, effective 8/28/13; **ARC 2016C**, IAB 6/10/15, effective 7/15/15; **ARC 2631C**, IAB 7/20/16, effective 8/24/16]

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 meet the experience requirement set forth in 18.10(3).

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; **ARC 2631C**, IAB 7/20/16, effective 8/24/16]

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.

[Filed 12/24/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]
[Filed ARC 8141B (Notice ARC 7873B, IAB 6/17/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8142B (Notice ARC 7874B, IAB 6/17/09), IAB 9/9/09, effective 10/14/09]
[Filed Emergency ARC 8248B, IAB 11/4/09, effective 10/12/09]
[Filed ARC 8958B (Notice ARC 8687B, IAB 4/7/10), IAB 7/28/10, effective 9/1/10]
[Filed ARC 9075B (Notice ARC 8830B, IAB 6/2/10), IAB 9/8/10, effective 10/13/10]
[Filed ARC 9383B (Notice ARC 9199B, IAB 11/3/10), IAB 2/23/11, effective 3/30/11]
[Filed ARC 9384B (Notice ARC 9200B, IAB 11/3/10), IAB 2/23/11, effective 3/30/11]
[Filed ARC 9385B (Notice ARC 9201B, IAB 11/3/10), IAB 2/23/11, effective 3/30/11]
[Filed ARC 9453B (Notice ARC 9306B, IAB 12/29/10), IAB 4/6/11, effective 5/11/11]
[Filed ARC 0564C (Notice ARC 0444C, IAB 11/14/12), IAB 1/23/13, effective 2/27/13]
[Filed ARC 0607C (Notice ARC 0493C, IAB 12/12/12), IAB 2/20/13, effective 3/27/13]
[Filed ARC 0872C (Notice ARC 0703C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0874C (Notice ARC 0701C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 1167C (Notice ARC 0988C, IAB 9/4/13), IAB 11/13/13, effective 12/18/13]
[Filed ARC 1326C (Notice ARC 1234C, IAB 12/11/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 2016C (Notice ARC 1918C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]
[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]
[Filed ARC 2631C (Notice ARC 2454C, IAB 3/16/16), IAB 7/20/16, effective 8/24/16]
[Filed ARC 3196C (Notice ARC 3012C, IAB 4/12/17), IAB 7/5/17, effective 8/9/17]

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 applicant for renewal or conversion is required to submit a completed application form with the applicant's signature to facilitate a check of the sex offender registry information under Iowa Code section 692A.121, the central registry for child abuse information established under Iowa Code chapter 235A, the central registry for dependent adult abuse information maintained under Iowa Code chapter 235B, and the Iowa court information system. The board may assess the applicant a fee no greater than the costs associated with obtaining and evaluating the background check.

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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15]

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 master educator license. Four units may also be earned for each National Board for Professional Teaching Standards certification renewal and may be used toward the subsequent renewal of either the standard or master educator license.

f. One unit may be earned upon the successful completion of an individualized professional development plan as verified by the supervising licensed evaluator.

[**ARC 2120C**, IAB 9/2/15, effective 10/7/15; **ARC 2587C**, IAB 6/22/16, effective 7/27/16]

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 master educator license. Four units may also be earned for each National Board for Professional Teaching Standards certification renewal and may be used toward the subsequent renewal of either the standard or master educator license.

f. One unit may be earned upon the successful completion of an individualized professional development plan as verified by the supervising licensed evaluator.
[**ARC 2120C**, IAB 9/2/15, effective 10/7/15; **ARC 2587C**, IAB 6/22/16, effective 7/27/16]

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 18.5(3), 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 18.5(3) 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; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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.

e. One unit may be earned upon the successful completion of an individualized professional development plan as verified by the supervising licensed evaluator, or in the case of a superintendent, as verified by the school board president.

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.

[**ARC 2587C**, IAB 6/22/16, effective 7/27/16]

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.

[Filed 12/24/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]
[Filed ARC 7988B (Notice ARC 7748B, IAB 5/6/09), IAB 7/29/09, effective 9/2/09]
[Filed ARC 9451B (Notice ARC 9300B, IAB 12/29/10), IAB 4/6/11, effective 5/11/11]
[Filed ARC 0026C (Notice ARC 9924B, IAB 12/14/11), IAB 3/7/12, effective 4/11/12]
[Filed ARC 2017C (Notice ARC 1919C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]
[Filed ARC 2120C (Notice ARC 2025C, IAB 6/10/15), IAB 9/2/15, effective 10/7/15]
[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]
[Filed ARC 2587C (Notice ARC 2452C, IAB 3/16/16), IAB 6/22/16, effective 7/27/16]
[Filed ARC 3196C (Notice ARC 3012C, IAB 4/12/17), IAB 7/5/17, effective 8/9/17]

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.

(7) Successful completion of CPR training as verified by a current certificate.

b. *Minimum age or diploma.* Applicants must have attained a minimum of 18 years. Applicants must also:

(1) Possess a minimum of:

1. A high school diploma,
2. A graduate equivalent diploma, or
3. Home school completion verified by the executive director; or

(2) Be 20 years of age or older.

c. *Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

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.

(4) Provide a current certificate of CPR training.

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.

22.1(7) *Transitional coaching authorization.*

a. *Application process.* Any person interested in the transitional coaching authorization shall submit a complete application verifying the requirements listed below. Application materials are available from the board of educational examiners online at http://www.boee.iowa.gov/.

b. *Requirements.* Applicants for the transitional coaching authorization shall have completed each of the following requirements:

(1) Verification that the applicant has not completed the coursework required for a coaching authorization.

(2) Verification of an offer of a coaching position by a school or a consortium of schools that will additionally verify that:

1. No fully authorized coaching candidates were found after a diligent search,

2. The transitional coach will be supervised by a licensed athletic director, administrator, or other practitioner serving in a supervisory role during the first two weeks of employment, and

3. The supervisor will evaluate the performance of the transitional coach using an evaluation form available on the school's Web site.

(3) Successful completion of an approved shortened course of training related to the code of professional rights and responsibilities, practices, and ethics specifically developed for transitional coaches.

(4) Successful completion of an approved child and dependent adult abuse mandatory reporter training course.

(5) Successful completion of a nationally recognized concussion in youth sports training course.

(6) Verification that the applicant has attained a minimum age of 21 years.

(7) Verification of completion of the background check requirements set forth in rule 282—13.1(272).

c. *Validity.* The transitional coaching authorization shall be valid for no more than one year and shall be valid only in the school or consortium of schools making the offer of the coaching position.

d. *Renewal.* The transitional coaching authorization is nonrenewable.

e. Revocation and suspension. Criteria of professional practice and rules of the board of educational examiners shall apply to holders of a transitional coaching authorization. An ethics complaint may be filed if a practitioner begins coaching a sport without current concussion training.

[**ARC 0865C**, IAB 7/24/13, effective 8/28/13; **ARC 0866C**, IAB 7/24/13, effective 8/28/13; **ARC 2230C**, IAB 11/11/15, effective 12/16/15; **ARC 2588C**, IAB 6/22/16, effective 7/27/16; **ARC 2793C**, IAB 11/9/16, effective 12/14/16; see Delay note at end of chapter]

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. For these individuals, the authorization will appear on the paraeducator certificate and will not include separate renewal requirements.

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) Background check. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

b. Validity. The substitute authorization shall be valid for five 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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15; **ARC 2528C**, IAB 5/11/16, effective 6/15/16]

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. *Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

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.

b. The standard school business official authorization shall be valid for three years.

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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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. Background check. The applicant must complete the background check requirements set forth in rule 282—13.1(272).

c. 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.

d. 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.

e. 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.

f. 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 conditional licenses may be issued to applicants holding the preliminary native language teaching authorization. No additional endorsement areas may be added.

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)*"d."*

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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15; **ARC 3196C**, IAB 7/5/17, effective 8/9/17]

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/.

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.* Applicanats must hold a high school degree or general equivalency diploma.

b. *Minimum age.* Applicants must have attained a minimum age of 18 years.

c. *Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15]

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. Background check. The applicant must complete the background check requirements set forth in rule 282—13.1(272).

c. 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.

d. The applicant must obtain a recommendation from an iJAG administrator verifying that the organization wishes to hire the applicant.

e. 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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15]

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. *Background check.* Applicants must complete the background check requirements set forth in rule 282—13.1(272).

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; **ARC 2230C**, IAB 11/11/15, effective 12/16/15]

282—22.11(272) Extension. For authorizations established in this chapter, a one-year extension may be issued if the applicant does not meet the requirements for authorization conversion or renewal. The applicant shall secure the signature of the superintendent or designee of the applicant's employer and

shall submit all required materials before the extension will be issued. This one-year extension is nonrenewable.

This rule is intended to implement Iowa Code section 272.31.

[**ARC 2121C**, IAB 9/2/15, effective 10/7/15]

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 7745B (Notice ARC 7329B, IAB 11/5/08), IAB 5/6/09, effective 6/10/09]
[Filed ARC 9572B (Notice ARC 9381B, IAB 2/23/11), IAB 6/29/11, effective 8/3/11]
[Filed ARC 0562C (Notice ARC 0443C, IAB 11/14/12), IAB 1/23/13, effective 2/27/13]
[Filed ARC 0865C (Notice ARC 0676C, IAB 4/3/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0866C (Notice ARC 0696C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 0869C (Notice ARC 0704C, IAB 5/1/13), IAB 7/24/13, effective 8/28/13]
[Filed ARC 1086C (Notice ARC 0877C, IAB 7/24/13), IAB 10/16/13, effective 11/20/13]
[Filed ARC 1087C (Notice ARC 0878C, IAB 7/24/13), IAB 10/16/13, effective 11/20/13]
[Filed ARC 1322C (Notice ARC 1180C, IAB 11/13/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 1542C (Notice ARC 1379C, IAB 3/19/14), IAB 7/23/14, effective 8/27/14]
[Filed ARC 1720C (Notice ARC 1552C, IAB 7/23/14), IAB 11/12/14, effective 12/17/14]
[Filed ARC 1719C (Notice ARC 1551C, IAB 7/23/14), IAB 11/12/14, effective 12/17/14]
[Filed ARC 1721C (Notice ARC 1604C, IAB 9/3/14), IAB 11/12/14, effective 12/17/14]
[Filed ARC 1718C (Notice ARC 1605C, IAB 9/3/14), IAB 11/12/14, effective 12/17/14]
[Filed ARC 2015C (Notice ARC 1917C, IAB 3/18/15), IAB 6/10/15, effective 7/15/15]
[Filed ARC 2121C (Notice ARC 2024C, IAB 6/10/15), IAB 9/2/15, effective 10/7/15]
[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]
[Filed ARC 2528C (Notice ARC 2411C, IAB 2/17/16), IAB 5/11/16, effective 6/15/16]
[Filed ARC 2588C (Notice ARC 2445C, IAB 3/16/16), IAB 6/22/16, effective 7/27/16]
[Filed ARC 2793C (Notice ARC 2690C, IAB 8/31/16), IAB 11/9/16, effective 12/14/16][1]
[Filed ARC 3196C (Notice ARC 3012C, IAB 4/12/17), IAB 7/5/17, effective 8/9/17]

[1] December 14, 2016, effective date of 22.1(2)*"a"*(7) and 22.1(4)*"a"*(4) [ARC 2793C, Item 2] delayed until the adjournment of the 2017 General Assembly by the Administrative Rules Review Committee at its meeting held December 13, 2016.

CHAPTER 24
PARAEDUCATOR CERTIFICATES

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

282—24.1(272) Paraeducator certificates. Iowa paraeducator certificates are issued upon application filed on a form provided by the board of educational examiners. Applicants must complete the background check requirements set forth in rule 282—13.1(272).

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

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

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

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

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

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

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

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

(1) Recognize the different developmental stages of students.

(2) Believe every student can learn.

(3) Recognize that each learner has unique learning needs that may require accommodations.

(4) Demonstrate knowledge of the common core, including competence in reading, writing and math.

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

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

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

(2) Organize materials to support teaching and learning.

(3) Facilitate the integration of students with diverse needs in various settings.

(4) Assist with special health services, under the supervision of a licensed health care provider.

(5) Promote a safe and positive learning environment.

(6) Function in various instructional settings (e.g., large group, small group, tutoring).

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

(1) Assist with learning activities and opportunities to accomplish instructional objectives.

(2) Support high expectations that are shared, clearly defined and appropriate.

(3) Monitor progress and document and report objective observations that inform instructional decisions.

(4) Effectively use verbal and nonverbal forms of communication with students.

(5) Assist with the implementation and use of instructional and assistive technology.

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

(1) Assist in modeling and teaching specific appropriate behaviors, social skills, and procedures that facilitate safety and learning in various environments.

(2) Assist in the implementation of individualized behavior management plans.

(3) Document and report objective observations on student behaviors.

(4) Assist in modifying the learning environment to manage behavior and social skills.

(5) Recognize that there is a cause or reason for misbehavior and assist in determining the cause or reason.

(6) Recognize, address, and report bullying.

(7) Recognize and report atypical emotional behavior.

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

(1) Demonstrate a commitment to work as an effective team member.

(2) Foster a professional and caring relationship with each student's family.

(3) Develop and maintain positive and professional relationships with students.

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

(1) Follow ethical practices for confidential information.

(2) Participate in ongoing professional development.

(3) Accept and apply constructive feedback.

(4) Abide by the Iowa code of ethics and professional practice rules of the board of educational examiners and rules of the Iowa department of education.

(5) Demonstrate the ability to separate personal issues from one's responsibilities in the workplace.

(6) Maintain a high level of competency and integrity.

(7) Share information regarding students' performance, behavior, or program with students' parents or guardians only as directed by the supervising teacher or educator.

(8) Be aware of personal biases and beliefs and refrain from discriminatory practices based on a student's disability, race, creed, color, religion, age, sex, sexual orientation, gender identity, disability, marital status, or national origin.

(9) Demonstrate ethical behavior when supporting students with graded activities, quizzes, and tests.

(10) Abide by Iowa law regarding the use of restraint and seclusion.

(11) Recognize that the paraeducator may not be given primary responsibility for the education of an individual student(s).

(12) Recognize that instructional decisions are made by the individualized education program (IEP) team for students with disabilities and that any changes to instruction, accommodations, supports, and services cannot be made outside the IEP team.

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

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

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

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

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

(1) Know and understand young children's typical and atypical developmental stages and their needs at each stage.

(2) Recognize multiple influences on young children's development and learning.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) Reserved.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

b. Work with the classroom teacher as collaborative partners.

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

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

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

f. Demonstrate knowledge of appropriate translation and interpretation procedures.

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

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

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

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

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

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

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

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

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

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

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

d. Be aware of and support the integration of literacy initiatives and content area standards, e.g., visual information and technology in support of the curriculum.

e. Be aware of the role school libraries play in improving student achievement, literacy, and lifelong learning.

f. Demonstrate an understanding of ethical issues related to school libraries, such as copyright, plagiarism, privacy, diversity, confidentiality, and freedom of speech.

g. Assist in the daily operations of the school library program, such as shelving, working with volunteers and student helpers, inventory, materials repair and maintenance.

h. Exhibit welcoming behaviors to all library patrons and visitors to encourage use of the library and its resources.

i. Demonstrate knowledge of the school library collection and the availability of other resources that will meet individual student information or research needs.

j. Demonstrate a general knowledge of basic technology skills and assist in troubleshooting basic hardware and software problems.

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

a. Understand the roles and responsibilities of the speech-language pathology paraeducator.

b. Demonstrate a basic understanding of the four areas of communication, including articulation, language, fluency, and voice, and how they occur through typical development.

c. Demonstrate an understanding of articulation/phonological disabilities.

d. Demonstrate an understanding of language disabilities.

e. Use appropriate instructional procedures and reinforcement techniques when working with children with articulation/phonological disabilities.

f. Use appropriate instructional procedures and reinforcement techniques when working with children with language disabilities.

g. Gather information as directed by the speech-language pathologist regarding the performance of children, including recording and charting responses.

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

a. Demonstrate knowledge of the impact of vision loss on learning and concept development for students who are blind or visually impaired.

(1) Demonstrate introductory knowledge of expanded core curriculum (ECC) and the ability to support ECC skills as directed by the supervising professional.

(2) Demonstrate introductory knowledge of functional vision assessments (FVA) and learning media assessments (LMA) of students who have vision impairments.

b. Demonstrate knowledge of and skills in technology appropriate to the needs of students with vision impairments.

(1) Operate and use assistive technology that supports students who have vision impairments.

(2) Support and strengthen each student's capability to access and utilize assistive technology.

c. Demonstrate introductory knowledge of instructional strategies unique to students who have vision impairments.

(1) Demonstrate the ability to adapt educational materials by using varied learning media as determined by student needs.

(2) Demonstrate an introductory knowledge of Braille in relation to identified or expressed student needs or both.

(3) Demonstrate introductory skills in operating transcription software and equipment.

d. Demonstrate introductory knowledge of motor skills, movement, orientation, and mobility for students with vision impairments.

e. Demonstrate knowledge of the role of paraeducators in student plans including individualized education programs (IEPs) and individualized family service plans (IFSPs).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[**ARC 8405B**, IAB 12/16/09, effective 1/20/10; **ARC 9204B**, IAB 11/3/10, effective 12/8/10; **ARC 1325C**, IAB 2/19/14, effective 3/26/14; **ARC 2529C**, IAB 5/11/16, effective 6/15/16; **ARC 3197C**, IAB 7/5/17, effective 8/9/17]

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

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

24.5(2) Possess an associate's degree or have earned 62 semester hours of college coursework from a regionally accredited institution of higher education.

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

282—24.6(272) Renewal requirements.

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

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

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

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

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

24.6(2) All applicants renewing a paraeducator certificate must submit documentation of completion of the child and dependent adult abuse 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.

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

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

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

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

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

These rules are intended to implement Iowa Code chapter 272.

[Filed 12/24/08, Notice 10/22/08—published 1/14/09, effective 2/18/09]
[Filed ARC 8405B (Notice ARC 8117B, IAB 9/9/09), IAB 12/16/09, effective 1/20/10]
[Filed ARC 9204B (Notice ARC 8960B, IAB 7/28/10), IAB 11/3/10, effective 12/8/10]
[Filed ARC 1325C (Notice ARC 1233C, IAB 12/11/13), IAB 2/19/14, effective 3/26/14]
[Filed ARC 2230C (Notice ARC 2130C, IAB 9/2/15), IAB 11/11/15, effective 12/16/15]
[Filed ARC 2529C (Notice ARC 2410C, IAB 2/17/16), IAB 5/11/16, effective 6/15/16]
[Filed ARC 3197C (Notice ARC 3047C, IAB 5/10/17), IAB 7/5/17, effective 8/9/17]

HUMAN SERVICES DEPARTMENT[441]

Rules transferred from Social Services Department[770] to Human Services Department[498], see 1983 Iowa Acts, Senate File 464, effective July 1, 1983.
Rules transferred from agency number [498] to [441] to conform with the reorganization numbering scheme in general, IAC Supp. 2/11/87.

TITLE I
GENERAL DEPARTMENTAL PROCEDURES

CHAPTER 1
DEPARTMENTAL ORGANIZATION AND PROCEDURES

1.1(17A)	Director
1.2(17A)	Council
1.3(17A)	Organization at state level
1.4(17A)	Field operations structure
1.5	Reserved
1.6(17A)	Mental health and developmental disabilities commission
1.7(17A)	Governor's developmental disabilities council (governor's DD council)
1.8(17A,217)	Waivers of administrative rules (hereinafter referred to as exceptions to policy)
1.9	Reserved
1.10(17A,514I)	HAWK-I board

CHAPTER 2
CONTRACTING OUT DEPARTMENT OF HUMAN SERVICES EMPLOYEES AND PROPERTY

2.1(23A,225C)	Definitions
2.2(23A,225C)	Contracts for use of the services of department employees
2.3(23A,225C)	Contract provisions
2.4(23A,225C)	Leasing of space at state institutions
2.5(23A,225C)	Requirements prior to leasing

CHAPTER 3
DEPARTMENT PROCEDURE FOR RULE MAKING

3.1(17A)	Applicability
3.2(17A)	Advice on possible rules before notice of proposed rule adoption
3.3(17A)	Public rule-making docket
3.4(17A)	Notice of proposed rule making
3.5(17A)	Public participation
3.6(17A)	Regulatory analysis
3.7(17A,25B)	Fiscal impact statement
3.8(17A)	Time and manner of rule adoption
3.9(17A)	Variance between adopted rule and published notice of proposed rule adoption
3.10(17A)	Exemptions from public rule-making procedures
3.11(17A)	Concise statement of reasons
3.12(17A)	Contents, style, and form of rule
3.13(17A)	Department rule-making record
3.14(17A)	Filing of rules
3.15(17A)	Effectiveness of rules prior to publication
3.16(17A)	Review by department of rules

CHAPTER 4
PETITIONS FOR RULE MAKING

4.1(17A)	Petition for rule making
4.2(17A)	Briefs

4.3(17A) Inquiries
4.4(17A) Agency consideration

CHAPTER 5
DECLARATORY ORDERS

5.1(17A) Petition for declaratory order
5.2(17A) Notice of petition
5.3(17A) Intervention
5.4(17A) Briefs
5.5(17A) Inquiries
5.6(17A) Service and filing of petitions and other papers
5.7(17A) Consideration
5.8(17A) Action on petition
5.9(17A) Refusal to issue order
5.10(17A) Contents of declaratory order—effective date
5.11(17A) Copies of orders
5.12(17A) Effect of a declaratory order

CHAPTER 6
Reserved

CHAPTER 7
APPEALS AND HEARINGS

7.1(17A) Definitions
7.2(17A) Conditions of an aggrieved person

DIVISION I

7.3(17A) Presiding officer
7.4(17A) Notification of hearing procedures
7.5(17A) The right to appeal
7.6(17A) Informing persons of their rights
7.7(17A) Notice of intent to approve, deny, terminate, reduce, or suspend assistance or deny reinstatement of assistance
7.8(17A) Opportunity for hearing
7.9(17A) Continuation of assistance pending a final decision on appeal
7.10(17A) Procedural considerations
7.11(17A) Information and referral for legal services
7.12(17A) Subpoenas
7.13(17A) Rights of appellants during hearings
7.14(17A) Limitation of persons attending
7.15(17A) Medical examination
7.16(17A) The appeal decision
7.17(17A) Exhausting administrative remedies
7.18(17A) Ex parte communication
7.19(17A) Accessibility of hearing decisions
7.20(17A) Right of judicial review and stays of agency action
7.21(17A) Food assistance hearings and appeals
7.22 Reserved
7.23(17A) Contested cases with no factual dispute
7.24(17A) Emergency adjudicative proceedings
7.25 to 7.40 Reserved

DIVISION II
APPEALS BASED ON THE COMPETITIVE PROCUREMENT BID PROCESS

7.41(17A) Scope and applicability
7.42(17A) Requests for timely filing of an appeal
7.43(17A) Bidder appeals
7.44(17A) Procedures for bidder appeal
7.45(17A) Stay of agency action for bidder appeal
7.46(17A) Request for review of the proposed decision
7.47(17A) Other procedural considerations
7.48(17A) Appeal record
7.49(17A) Pleadings
7.50(17A) Ex parte communications
7.51(17A) Right of judicial review

CHAPTER 8
PAYMENT OF SMALL CLAIMS

8.1(217) Authorization to reimburse

CHAPTER 9
PUBLIC RECORDS AND FAIR
INFORMATION PRACTICES

9.1(17A,22) Definitions
9.2(17A,22) Statement of policy
9.3(17A,22) Requests for access to records
9.4(17A,22) Access to confidential records
9.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examinations
9.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
9.7(17A,22,228) Consent to disclosure by the subject of a confidential record
9.8(17A,22) Notice to suppliers of information
9.9(17A,22) Release to subject
9.10(17A,22) Use and disclosure without consent of the subject
9.11(22) Availability of records
9.12(22,252G) Personally identifiable information
9.13(217) Distribution of informational materials
9.14(17A,22) Special policies and procedures for protected health information
9.15(17A,22) Person who may exercise rights of the subject

CHAPTER 10
Reserved

CHAPTER 11
COLLECTION OF PUBLIC ASSISTANCE DEBTS

11.1(217) Definitions
11.2(217) Establishment of claim
11.3(217) Application of payment
11.4(217) Setoff against state income tax refund, rebate, or other state payments, including, for example, state employee wages
11.5(234) Setoff against federal income tax refund or other federal payments, including, for example, federal employee wages

CHAPTER 12
VOLUNTEER SERVICES

12.1(234) Definition
12.2(234) Allocation of block grant funds
12.3(234) Requirements for volunteers
12.4(234) Volunteer service programs
12.5(234) Services and benefits available to volunteers

CHAPTER 13
PROGRAM EVALUATION

13.1(234,239B,249A) Definitions
13.2(234,239B,249A) Review of public assistance records by the department
13.3(234,239B,249A) Who shall be reviewed
13.4(234,239B,249A) Notification of review
13.5(234,239B,249A) Review procedure
13.6(234,239B,249A) Failure to cooperate
13.7(234,239B,249A) Report of findings
13.8(234,239B,249A) Federal rereview

CHAPTER 14
OFFSET OF COUNTY DEBTS OWED DEPARTMENT

14.1(217,234) Definitions
14.2(217,234) Identifying counties with liabilities
14.3(217,234) List of counties with amounts owed
14.4(217,234) Notification to county regarding offset
14.5(217,234) Implementing the final decision
14.6(217,234) Offset completed

CHAPTER 15
RESOLUTION OF LEGAL SETTLEMENT DISPUTES

15.1(225C) Definitions
15.2(225C) Assertion of legal settlement dispute
15.3(225C) Response to dispute notification
15.4(225C) Contested case hearing
15.5(225C) Change in determination

TITLE II
Reserved

CHAPTERS 16 to 21
Reserved

TITLE III
MENTAL HEALTH

CHAPTER 22
AUTISM SUPPORT PROGRAM

22.1(225D) Definitions
22.2(225D) Eligibility and application requirements
22.3(225D) Cost-sharing requirements and graduated schedule of cost sharing
22.4(225D) Review of financial eligibility, cost-sharing requirements, exemption from cost sharing, and disenrollment in the program
22.5(225D) Initial service authorization and renewal of service authorization
22.6(225D) Provider network

22.7(225D) Financial management of the program
22.8(225D) Appeal

CHAPTER 23
MENTAL HEALTH AND DISABILITY SERVICES
REDESIGN TRANSITION FUND

23.1(225C,84GA,SF2315) Definitions
23.2(225C,84GA,SF2315) Eligibility
23.3(225C,84GA,SF2315) Application requirements
23.4(225C,84GA,SF2315) Guidelines for the management of transition funds
23.5(225C,84GA,SF2315) Allocation of transition funds

CHAPTER 24
ACCREDITATION OF PROVIDERS OF SERVICES TO PERSONS WITH MENTAL ILLNESS, INTELLECTUAL DISABILITIES, OR DEVELOPMENTAL DISABILITIES

DIVISION I
SERVICES FOR INDIVIDUALS WITH DISABILITIES

24.1(225C) Definitions
24.2(225C) Standards for policy and procedures
24.3(225C) Standards for organizational activities
24.4(225C) Standards for services
24.5(225C) Accreditation
24.6(225C) Deemed status
24.7(225C) Complaint process
24.8(225C) Appeal procedure
24.9(225C) Exceptions to policy
24.10 to 24.19 Reserved

DIVISION II
CRISIS RESPONSE SERVICES

24.20(225C) Definitions
24.21(225C) Standards for crisis response services
24.22(225C) Standards for policies and procedures
24.23(225C) Standards for organizational activities
24.24(225C) Standards for crisis response staff
24.25(225C) Standards for services
24.26(225C) Accreditation
24.27(225C) Deemed status
24.28(225C) Complaint process
24.29(225C) Appeal procedure
24.30(225C) Exceptions to policy
24.31(225C) Standards for individual crisis response services
24.32(225C) Crisis evaluation
24.33(225C) Twenty-four-hour crisis response
24.34(225C) Twenty-four-hour crisis line
24.35(225C) Warm line
24.36(225C) Mobile response
24.37(225C) Twenty-three-hour crisis observation and holding
24.38(225C) Crisis stabilization community-based services (CSCBS)
24.39(225C) Crisis stabilization residential services (CSRS)
24.40(225C) Medication—administration, storage and documentation

CHAPTER 25
DISABILITY SERVICES MANAGEMENT

DIVISION I
REGIONAL CORE SERVICES

25.1(331) Definitions
25.2(331) Core service domains
25.3(331) Access standards
25.4(331) Practices
25.5 to 25.10 Reserved

DIVISION II
REGIONAL SERVICE SYSTEM

25.11(331) Definitions
25.12(331) Regional governance structure
25.13(331) Regional finances
25.14(331) Regional governance agreement
25.15(331) Eligibility, diagnosis, and functional assessment criteria
25.16(331) Financial eligibility requirements
25.17(331) Exempted counties
25.18(331) Annual service and budget plan
25.19(331) Annual service and budget plan approval
25.20(331) Annual report
25.21(331) Policies and procedures manual for the regional service system
25.22 to 25.40 Reserved

DIVISION III
MINIMUM DATA SET

25.41(331) Minimum data set
25.42 to 25.50 Reserved

DIVISION IV
INCENTIVE AND EFFICIENCY POOL FUNDING

25.51(77GA,HF2545) Desired results areas
25.52(77GA,HF2545) Methodology for applying for incentive funding
25.53(77GA,HF2545) Methodology for awarding incentive funding
25.54(77GA,HF2545) Subsequent year performance factors
25.55(77GA,HF2545) Phase-in provisions
25.56 to 25.60 Reserved

DIVISION V
RISK POOL FUNDING

25.61(426B) Definitions
25.62(426B) Risk pool board
25.63(426B) Application process
25.64(426B) Methodology for awarding risk pool funding
25.65(426B) Repayment provisions
25.66(426B) Appeals
25.67 to 25.70 Reserved

DIVISION VI
TOBACCO SETTLEMENT FUND RISK POOL FUNDING

25.71(78GA,ch1221) Definitions
25.72(78GA,ch1221) Risk pool board
25.73(78GA,ch1221) Rate-setting process
25.74(78GA,ch1221) Application process
25.75(78GA,ch1221) Methodology for awarding tobacco settlement fund risk pool funding

25.76(78GA,ch1221) Repayment provisions
25.77(78GA,ch1221) Appeals
25.78 to 25.80 Reserved

DIVISION VII
COMMUNITY MENTAL HEALTH CENTER WAIVER REQUEST

25.81(225C) Waiver request
25.82 to 25.90 Reserved

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

25.91(331) Exemption from joining into mental health and disability services region
25.92 to 25.94 Reserved

DIVISION IX
DATA SUBMISSION TO DETERMINE MEDICAID OFFSET FOR COUNTIES

25.95(426B) Definitions
25.96(426B) Data to determine Medicaid offset
25.97 to 25.100 Reserved

DIVISION X
MENTAL HEALTH ADVOCATES

25.101(229) Definitions
25.102(229) Advocate appointment and qualifications
25.103(229) Advocate assignment
25.104(229) Advocate responsibilities
25.105(229) County responsibilities
25.106(229) Data collection requirements
25.107(229) Quality assurance system
25.108 to 25.116 Reserved

DIVISION XI
PROCESS FOR APPROVING SUBACUTE MENTAL HEALTH CARE FACILITY LICENSING APPLICATIONS TO THE DEPARTMENT OF INSPECTIONS AND APPEALS

25.117(135G) Definitions
25.118(135G) Approval process for subacute care facility applications to be licensed by the department of inspections and appeals

CHAPTERS 26 and 27
Reserved

CHAPTER 28
POLICIES FOR MENTAL HEALTH
INSTITUTES AND RESOURCE CENTERS

28.1(218) Definitions
28.2(218,222) Selection of facility
28.3 Reserved
28.4(225C,229) Grievances
28.5(217,218) Photographing and recording of individuals and use of cameras
28.6(217,218) Interviews and statements
28.7(218) Use of grounds, facilities, or equipment
28.8(218) Tours of facility
28.9(218) Donations
28.10 and 28.11 Reserved
28.12(217) Release of confidential information
28.13(218) Applying county institutional credit balances

CHAPTER 29
MENTAL HEALTH INSTITUTES

29.1(218) Catchment areas
29.2(218,229) Voluntary admissions
29.3(229,230) Certification of county of residence
29.4(218,230) Charges for care
29.5(229) Authorization for treatment
29.6(217,228,229) Rights of individuals
29.7(218) Visiting

CHAPTER 30
STATE RESOURCE CENTERS

30.1(218,222) Catchment areas
30.2(218,222) Admission
30.3(222) Non-Medicaid payment-eligible individuals
30.4(222) Liability for support
30.5(217,218,225C) Rights of individuals
30.6(218) Visiting

CHAPTER 31
CIVIL COMMITMENT UNIT

31.1(229A) Definitions
31.2(229A) Visitation
31.3(229A) Group visitation
31.4(229A) Grievances
31.5(229A) Photographing and recording individuals
31.6(229A) Release of information
31.7(229A) Communication with individuals
31.8(229A) Building and grounds
31.9(8,218) Gifts and bequests
31.10(229A) Cost of care

CHAPTERS 32 and 33
Reserved

CHAPTER 34
ALTERNATIVE DIAGNOSTIC FACILITIES

34.1(225C) Definitions
34.2(225C) Function
34.3(225C) Standards

CHAPTER 35
Reserved

CHAPTER 36
FACILITY ASSESSMENTS

DIVISION I
ASSESSMENT FEE FOR INTERMEDIATE CARE FACILITIES FOR PERSONS WITH AN INTELLECTUAL DISABILITY

36.1(249A) Assessment of fee
36.2(249A) Determination and payment of fee
36.3 Reserved
36.4(249A) Termination of fee assessment
36.5 Reserved

DIVISION II
QUALITY ASSURANCE ASSESSMENT FOR NURSING FACILITIES

36.6(249L) Assessment
36.7(249L) Determination and payment of assessment
36.8 and 36.9 Reserved

DIVISION III
HEALTH CARE ACCESS ASSESSMENT FOR HOSPITALS

36.10(249M) Application of assessment
36.11(249M) Determination and payment of assessment
36.12(249M) Termination of health care access assessment

CHAPTER 37
Reserved

CHAPTER 38
DEVELOPMENTAL DISABILITIES BASIC STATE GRANT

38.1(225C,217) Definitions
38.2(225C,217) Program eligibility
38.3(225C,217) Application under competitive process
38.4(225C,217) Competitive project awards
38.5(225C,217) Sole source or emergency selection project awards
38.6(225C,217) Field-initiated proposals
38.7(225C,217) Notification
38.8(225C,217) Request for reconsideration
38.9(225C,217) Contracts
38.10 Reserved
38.11(225C,217) Reallocation of funds
38.12(225C,217) Conflict of interest policy

CHAPTER 39
Reserved

TITLE IV
FAMILY INVESTMENT PROGRAM

CHAPTER 40
APPLICATION FOR AID

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

40.1 to 40.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

40.21(239B) Definitions
40.22(239B) Application
40.23(239B) Date of application
40.24(239B) Procedure with application
40.25(239B) Time limit for decision
40.26(239B) Effective date of grant
40.27(239B) Continuing eligibility
40.28(239B) Referral for investigation

CHAPTER 41
GRANTING ASSISTANCE

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

41.1 to 41.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

41.21(239B) Eligibility factors specific to child
41.22(239B) Eligibility factors specific to payee
41.23(239B) Home, residence, citizenship, and alienage
41.24(239B) Promoting independence and self-sufficiency through employment job opportunities and basic skills (PROMISE JOBS) program
41.25(239B) Uncategorized factors of eligibility
41.26(239B) Resources
41.27(239B) Income
41.28(239B) Need standards
41.29(239B) Composite FIP/SSI cases
41.30(239B) Time limits

CHAPTER 42
Reserved

CHAPTER 43
ALTERNATE PAYEES

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

43.1 to 43.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

43.21(239B) Conservatorship or guardianship
43.22 and 43.23 Reserved
43.24(239B) Emergency payee

CHAPTER 44
Reserved

CHAPTER 45
PAYMENT

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

45.1 to 45.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

45.21(239B) Issuing payment
45.22(239B) Return
45.23(239B) Held warrants
45.24(239B) Underpayment
45.25(239B) Deceased payees
45.26(239B) Limitation on payment
45.27(239B) Rounding of need standard and payment amount

CHAPTER 46
OVERPAYMENT RECOVERY

DIVISION I
FAMILY INVESTMENT PROGRAM—CONTROL GROUP

46.1 to 46.20 Reserved

DIVISION II
FAMILY INVESTMENT PROGRAM—TREATMENT GROUP

46.21(239B) Definitions
46.22(239B) Monetary standards
46.23(239B) Notification and appeals
46.24(239B) Determination of overpayments
46.25(239B) Source of recoupment
46.26 Reserved
46.27(239B) Procedures for recoupment
46.28 Reserved
46.29(239B) Fraudulent misrepresentation of residence

CHAPTER 47
DIVERSION INITIATIVES

DIVISION I
PROMOTING AWARENESS OF THE BENEFITS OF A HEALTHY MARRIAGE

47.1(234) Eligibility criteria
47.2(234) Notice and eligibility period
47.3 to 47.20 Reserved

DIVISION II
FAMILY SELF-SUFFICIENCY GRANTS PROGRAM

47.21(239B) Definitions
47.22(239B) Availability of the family self-sufficiency grants program
47.23(239B) General criteria
47.24(239B) Assistance available in family self-sufficiency grants
47.25(239B) Application, notification, and appeals
47.26(239B) Approved local plans for family self-sufficiency grants
47.27(239B) Evaluation of family self-sufficiency grants
47.28(239B) Recovery of FSSG overpayments

CHAPTERS 48 and 49
Reserved

TITLE V
STATE SUPPLEMENTARY ASSISTANCE

CHAPTER 50
APPLICATION FOR ASSISTANCE

50.1(249) Definitions
50.2(249) Application procedures
50.3(249) Approval of application and effective date of eligibility
50.4(249) Reviews
50.5(249) Application under conditional benefits

CHAPTER 51
ELIGIBILITY

51.1(249) Application for other benefits
51.2(249) Supplementation
51.3(249) Eligibility for residential care

51.4(249) Dependent relatives
51.5(249) Residence
51.6(249) Eligibility for supplement for Medicare and Medicaid eligibles
51.7(249) Income from providing room and board
51.8(249) Furnishing of social security number
51.9(249) Recovery

CHAPTER 52
PAYMENT

52.1(249) Assistance standards

CHAPTER 53
Reserved

CHAPTER 54
FACILITY PARTICIPATION

54.1(249) Application and contract agreement
54.2(249) Maintenance of case records
54.3(249) Financial and statistical report
54.4(249) Goods and services provided
54.5(249) Personal needs account
54.6(249) Case activity report
54.7(249) Billing procedures
54.8(249) Audits

TITLE VI
GENERAL PUBLIC ASSISTANCE PROVISIONS

CHAPTERS 55 and 56
Reserved

CHAPTER 57
INTERIM ASSISTANCE REIMBURSEMENT

57.1(249) Definitions
57.2(249) Requirements for reimbursement
57.3(249) Certificate of authority

CHAPTER 58
EMERGENCY ASSISTANCE

DIVISION I
IOWA DISASTER AID INDIVIDUAL ASSISTANCE GRANT PROGRAM

58.1(29C) Definitions
58.2(29C) Program implementation
58.3(29C) Application for assistance
58.4(29C) Eligibility criteria
58.5(29C) Eligible categories of assistance
58.6(29C) Eligibility determination and payment
58.7(29C) Contested cases
58.8(29C) Discontinuance of program
58.9 to 58.20 Reserved

DIVISION II
IOWA DISASTER CASE MANAGEMENT

58.21(29C) Purpose
58.22(29C) Definitions

58.23(29C) Program implementation
58.24(29C) Eligibility criteria
58.25(29C) Services
58.26(29C) Disaster-caused unmet needs
58.27(29C) Resources
58.28(29C) Standards and policies
58.29(29C) Planning and training
58.30(29C) Payment for services
58.31(29C) Contested cases

CHAPTER 59
Reserved

CHAPTER 60
REFUGEE CASH ASSISTANCE

60.1(217) Alienage requirements
60.2(217) Application procedures
60.3(217) Effective date of grant
60.4(217) Accepting other assistance
60.5(217) Eligibility factors
60.6(217) Students in institutions of higher education
60.7(217) Time limit for eligibility
60.8(217) Criteria for exemption from registration for employment services, registration, and refusal to register
60.9(217) Work and training requirements
60.10(217) Uncategorized factors of eligibility
60.11(217) Temporary absence from home
60.12(217) Application
60.13(217) Continuing eligibility
60.14(217) Alternate payees
60.15(217) Payment
60.16(217) Overpayment recovery

CHAPTER 61
REFUGEE SERVICES PROGRAM

61.1(217) Definitions
61.2(217) Authority
61.3(217) Eligibility for refugee services
61.4(217) Planning and coordinating the placement of refugees in advance of their arrival
61.5(217) Services of the department available for refugees
61.6(217) Provision of services
61.7(217) Application for services
61.8(217) Adverse service actions
61.9(217) Client appeals
61.10(217) Refugee sponsors
61.11(217) Adverse actions regarding sponsor applications
61.12(217) Administrative review of denial of sponsorship application
61.13(217) Refugee resettlement moneys
61.14(217) Unaccompanied refugee minors program
61.15(217,622A) Interpreters and translators for legal proceedings
61.16(217) Pilot recredentialing services
61.17(217) Targeted assistance grants
61.18(217) Iowa refugee services foundation

CHAPTERS 62 to 64
Reserved

TITLE VII
FOOD PROGRAMS

CHAPTER 65
FOOD ASSISTANCE PROGRAM ADMINISTRATION

DIVISION I

65.1(234)	Definitions
65.2(234)	Application
65.3(234)	Administration of program
65.4(234)	Issuance
65.5(234)	Simplified reporting
65.6(234)	Delays in certification
65.7	Reserved
65.8(234)	Deductions
65.9(234)	Treatment centers and group living arrangements
65.10	Reserved
65.11(234)	Discrimination complaint
65.12(234)	Appeals
65.13(234)	Joint processing
65.14	Reserved
65.15(234)	Proration of benefits
65.16(234)	Complaint system
65.17(234)	Involvement in a strike
65.18 and 65.19	Reserved
65.20(234)	Notice of expiration issuance
65.21(234)	Claims
65.22(234)	Verification
65.23(234)	Prospective budgeting
65.24(234)	Inclusion of foster children in household
65.25(234)	Effective date of change
65.26(234)	Eligible students
65.27(234)	Voluntary quit or reduction in hours of work
65.28(234)	Work requirements
65.29(234)	Income
65.30(234)	Resources
65.31(234)	Homeless meal providers
65.32(234)	Basis for allotment
65.33(234)	Dependent care deduction
65.34 to 65.36	Reserved
65.37(234)	Eligibility of noncitizens
65.38(234)	Income deductions
65.39(234)	Categorical eligibility
65.40	Reserved
65.41(234)	Actions on changes increasing benefits
65.42 and 65.43	Reserved
65.44(234)	Reinstatement
65.45	Reserved
65.46(234)	Disqualifications
65.47 to 65.49	Reserved
65.50(234)	No increase in benefits

65.51(234) State income and eligibility verification system
65.52(234) Systematic alien verification for entitlements (SAVE) program

CHAPTER 66
EMERGENCY FOOD ASSISTANCE PROGRAM

66.1(234) Definitions
66.2(234) Application to be a TEFAP contractor
66.3(234) Contracts
66.4(234) Distribution
66.5(234) Household eligibility
66.6(234) Reimbursement for allowable costs
66.7(234) Commodity losses and claims
66.8(234) State monitoring
66.9(234) Limits on unrelated activities
66.10(234) Complaints

CHAPTERS 67 to 72
Reserved

TITLE VIII
MEDICAL ASSISTANCE

CHAPTER 73
MANAGED CARE

73.1(249A) Definitions
73.2(249A) Contracts with a managed care organization
73.3(249A) Enrollment
73.4(249A) Disenrollment process
73.5(249A) Covered services
73.6(249A) Amount, duration and scope of services
73.7(249A) Emergency services
73.8(249A) Access to service
73.9(249A) Incident reporting
73.10(249A) Discharge planning
73.11(249A) Level of care assessment and annual reviews
73.12(249A) Appeal of managed care organization actions
73.13(249A) Appeal to department
73.14(249A) Continuation of benefits
73.15(249A) Grievances
73.16(249A) Written record
73.17(249A) Information concerning procedures relating to the review of managed care organization decisions and actions
73.18(249A) Records and reports
73.19(249A) Audits
73.20(249A) Marketing
73.21(249A) Enrollee education
73.22(249A) Payment to the managed care organization
73.23(249A) Claims payment by the managed care organization
73.24(249A) Quality assurance
73.25(249A) Certifications and program integrity

CHAPTER 74
IOWA HEALTH AND WELLNESS PLAN

74.1(249A,85GA,SF446) Definitions
74.2(249A,85GA,SF446) Eligibility factors
74.3(249A,85GA,SF446) Application
74.4(249A,85GA,SF446) Financial eligibility
74.5(249A,85GA,SF446) Enrollment period
74.6(249A,85GA,SF446) Reporting changes
74.7(249A,85GA,SF446) Reenrollment
74.8(249A,85GA,SF446) Terminating enrollment
74.9(249A,85GA,SF446) Recovery
74.10(249A,85GA,SF446) Right to appeal
74.11(249A,85GA,SF446) Financial participation
74.12(249A,85GA,SF446) Benefits and service delivery
74.13(249A,85GA,SF446) Claims and reimbursement methodologies
74.14(249A,85GA,SF446) Discontinuance of program

CHAPTER 75
CONDITIONS OF ELIGIBILITY

DIVISION I
GENERAL CONDITIONS OF ELIGIBILITY, COVERAGE GROUPS, AND SSI-RELATED PROGRAMS

75.1(249A) Persons covered
75.2(249A) Medical resources
75.3(249A) Acceptance of other financial benefits
75.4(249A) Medical assistance lien
75.5(249A) Determination of countable income and resources for persons in a medical institution
75.6(249A) Entrance fee for continuing care retirement community or life care community
75.7(249A) Furnishing of social security number
75.8(249A) Medical assistance corrective payments
75.9(249A) Treatment of Medicaid qualifying trusts
75.10(249A) Residency requirements
75.11(249A) Citizenship or alienage requirements
75.12(249A) Inmates of public institutions
75.13(249A) Categorical relatedness
75.14(249A) Establishing paternity and obtaining support
75.15(249A) Disqualification for long-term care assistance due to substantial home equity
75.16(249A) Client participation in payment for medical institution care
75.17(249A) Verification of pregnancy
75.18(249A) Continuous eligibility for pregnant women
75.19(249A) Continuous eligibility for children
75.20(249A) Disability requirements for SSI-related Medicaid
75.21(249A) Health insurance premium payment (HIPP) program
75.22(249A) AIDS/HIV health insurance premium payment program
75.23(249A) Disposal of assets for less than fair market value after August 10, 1993
75.24(249A) Treatment of trusts established after August 10, 1993
75.25(249A) Definitions
75.26 Reserved
75.27(249A) AIDS/HIV settlement payments
75.28(249A) Recovery
75.29(249A) Investigation by quality control or the department of inspections and appeals
75.30 to 75.49 Reserved

DIVISION II
ELIGIBILITY FACTORS SPECIFIC TO COVERAGE GROUPS RELATED TO
THE FAMILY MEDICAL ASSISTANCE PROGRAM (FMAP)

75.50(249A) Definitions
75.51 Reserved
75.52(249A) Continuing eligibility
75.53(249A) Iowa residency policies specific to FMAP and FMAP-related coverage groups
75.54(249A) Eligibility factors specific to child
75.55(249A) Eligibility factors specific to specified relatives
75.56(249A) Resources
75.57(249A) Income
75.58(249A) Need standards
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
75.60(249A) Pending SSI approval
75.61 to 75.69 Reserved

DIVISION III
FINANCIAL ELIGIBILITY BASED ON MODIFIED ADJUSTED GROSS INCOME (MAGI)

75.70(249A) Financial eligibility based on modified adjusted gross income (MAGI)
75.71(249A) Income limits

CHAPTER 76
ENROLLMENT AND REENROLLMENT

76.1(249A) Definitions
76.2(249A) Application with the department
76.3(249A) Referrals from a health insurance marketplace
76.4(249A) Express lane eligibility
76.5(249A) Enrollment through SSI
76.6(249A) Referral for Medicare savings program
76.7(249A) Presumptive eligibility
76.8(249A) Applicant responsibilities
76.9(249A) Responsible persons and authorized representatives
76.10(249A) Right to withdraw the application
76.11(249A) Choice of electronic notifications
76.12(249A) Application not required
76.13(249A) Initial enrollment
76.14(249A) Reenrollment
76.15(249A) Report of changes
76.16(249A) Action on information received
76.17(249A) Automatic redetermination of eligibility

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS
OF MEDICAL AND REMEDIAL CARE

77.1(249A) Physicians
77.2(249A) Retail pharmacies
77.3(249A) Hospitals
77.4(249A) Dentists
77.5(249A) Podiatrists
77.6(249A) Optometrists
77.7(249A) Opticians
77.8(249A) Chiropractors

77.9(249A) Home health agencies
77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies
77.11(249A) Ambulance service
77.12(249A) Behavioral health intervention
77.13(249A) Hearing aid dispensers
77.14(249A) Audiologists
77.15(249A) Community mental health centers
77.16(249A) Screening centers
77.17(249A) Physical therapists
77.18(249A) Orthopedic shoe dealers and repair shops
77.19(249A) Rehabilitation agencies
77.20(249A) Independent laboratories
77.21(249A) Rural health clinics
77.22(249A) Psychologists
77.23(249A) Maternal health centers
77.24(249A) Ambulatory surgical centers
77.25(249A) Home- and community-based habilitation services
77.26(249A) Behavioral health services
77.27(249A) Birth centers
77.28(249A) Area education agencies
77.29(249A) Case management provider organizations
77.30(249A) HCBS health and disability waiver service providers
77.31(249A) Occupational therapists
77.32(249A) Hospice providers
77.33(249A) HCBS elderly waiver service providers
77.34(249A) HCBS AIDS/HIV waiver service providers
77.35(249A) Federally qualified health centers
77.36(249A) Advanced registered nurse practitioners
77.37(249A) Home- and community-based services intellectual disability waiver service providers
77.38(249A) Assertive community treatment
77.39(249A) HCBS brain injury waiver service providers
77.40(249A) Lead inspection agencies
77.41(249A) HCBS physical disability waiver service providers
77.42(249A) Public health agencies
77.43(249A) Infant and toddler program providers
77.44(249A) Local education agency services providers
77.45(249A) Indian health facilities
77.46(249A) HCBS children's mental health waiver service providers
77.47(249A) Health home services providers
77.48(249A) Speech-language pathologists
77.49(249A) Physician assistants
77.50(249A) Ordering and referring providers
77.51(249A) Child care medical services
77.52(249A) Community-based neurobehavioral rehabilitation services

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF
MEDICAL AND REMEDIAL SERVICES

78.1(249A) Physicians' services
78.2(249A) Prescribed outpatient drugs
78.3(249A) Inpatient hospital services

78.4(249A)	Dentists
78.5(249A)	Podiatrists
78.6(249A)	Optometrists
78.7(249A)	Opticians
78.8(249A)	Chiropractors
78.9(249A)	Home health agencies
78.10(249A)	Durable medical equipment (DME), prosthetic devices and medical supplies
78.11(249A)	Ambulance service
78.12(249A)	Behavioral health intervention
78.13(249A)	Nonemergency medical transportation
78.14(249A)	Hearing aids
78.15(249A)	Orthopedic shoes
78.16(249A)	Community mental health centers
78.17(249A)	Physical therapists
78.18(249A)	Screening centers
78.19(249A)	Rehabilitation agencies
78.20(249A)	Independent laboratories
78.21(249A)	Rural health clinics
78.22(249A)	Family planning clinics
78.23(249A)	Other clinic services
78.24(249A)	Psychologists
78.25(249A)	Maternal health centers
78.26(249A)	Ambulatory surgical center services
78.27(249A)	Home- and community-based habilitation services
78.28(249A)	List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review
78.29(249A)	Behavioral health services
78.30(249A)	Birth centers
78.31(249A)	Hospital outpatient services
78.32(249A)	Area education agencies
78.33(249A)	Case management services
78.34(249A)	HCBS ill and handicapped waiver services
78.35(249A)	Occupational therapist services
78.36(249A)	Hospice services
78.37(249A)	HCBS elderly waiver services
78.38(249A)	HCBS AIDS/HIV waiver services
78.39(249A)	Federally qualified health centers
78.40(249A)	Advanced registered nurse practitioners
78.41(249A)	HCBS intellectual disability waiver services
78.42(249A)	Pharmacies administering influenza vaccine to children
78.43(249A)	HCBS brain injury waiver services
78.44(249A)	Lead inspection services
78.45(249A)	Assertive community treatment
78.46(249A)	Physical disability waiver service
78.47(249A)	Pharmaceutical case management services
78.48(249A)	Public health agencies
78.49(249A)	Infant and toddler program services
78.50(249A)	Local education agency services
78.51(249A)	Indian health service 638 facility services
78.52(249A)	HCBS children's mental health waiver services
78.53(249A)	Health home services
78.54(249A)	Speech-language pathology services

78.55(249A) Services rendered via telehealth
78.56(249A) Community-based neurobehavioral rehabilitation services
78.57(249A) Child care medical services

CHAPTER 79
OTHER POLICIES RELATING TO PROVIDERS OF
MEDICAL AND REMEDIAL CARE

79.1(249A) Principles governing reimbursement of providers of medical and health services
79.2(249A) Sanctions
79.3(249A) Maintenance of records by providers of service
79.4(249A) Reviews and audits
79.5(249A) Nondiscrimination on the basis of handicap
79.6(249A) Provider participation agreement
79.7(249A) Medical assistance advisory council
79.8(249A) Requests for prior authorization
79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services
79.10(249A) Requests for preadmission review
79.11(249A) Requests for preprocedure surgical review
79.12(249A) Advance directives
79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services
79.14(249A) Provider enrollment
79.15(249A) Education about false claims recovery
79.16(249A) Electronic health record incentive program

CHAPTER 80
PROCEDURE AND METHOD OF PAYMENT

80.1 Reserved
80.2(249A) Submission of claims
80.3(249A) Payment from other sources
80.4(249A) Time limit for submission of claims and claim adjustments
80.5(249A) Authorization process
80.6(249A) Payment to provider—exception
80.7(249A) Health care data match program

CHAPTER 81
NURSING FACILITIES

DIVISION I
GENERAL POLICIES

81.1(249A) Definitions
81.2 Reserved
81.3(249A) Initial approval for nursing facility care
81.4(249A) Arrangements with residents
81.5(249A) Discharge and transfer
81.6(249A) Financial and statistical report and determination of payment rate
81.7(249A) Continued review
81.8 Reserved
81.9(249A) Records
81.10(249A) Payment procedures
81.11(249A) Billing procedures
81.12(249A) Closing of facility
81.13(249A) Conditions of participation for nursing facilities
81.14(249A) Audits

81.15 Reserved
81.16(249A) Nurse aide requirements and training and testing programs
81.17 Reserved
81.18(249A) Sanctions
81.19 Reserved
81.20(249A) Out-of-state facilities
81.21(249A) Outpatient services
81.22(249A) Rates for Medicaid eligibles
81.23(249A) State-funded personal needs supplement
81.24 to 81.30 Reserved

DIVISION II
ENFORCEMENT OF COMPLIANCE

81.31(249A) Definitions
81.32(249A) General provisions
81.33(249A) Factors to be considered in selecting remedies
81.34(249A) Available remedies
81.35(249A) Selection of remedies
81.36(249A) Action when there is immediate jeopardy
81.37(249A) Action when there is no immediate jeopardy
81.38(249A) Action when there is repeated substandard quality of care
81.39(249A) Temporary management
81.40(249A) Denial of payment for all new admissions
81.41(249A) Secretarial authority to deny all payments
81.42(249A) State monitoring
81.43(249A) Directed plan of correction
81.44(249A) Directed in-service training
81.45(249A) Closure of a facility or transfer of residents, or both
81.46(249A) Civil money penalties—basis for imposing penalty
81.47(249A) Civil money penalties—when penalty is collected
81.48(249A) Civil money penalties—notice of penalty
81.49(249A) Civil money penalties—waiver of hearing, reduction of penalty amount
81.50(249A) Civil money penalties—amount of penalty
81.51(249A) Civil money penalties—effective date and duration of penalty
81.52(249A) Civil money penalties—due date for payment of penalty
81.53(249A) Use of penalties collected by the department
81.54(249A) Continuation of payments to a facility with deficiencies
81.55(249A) State and federal disagreements involving findings not in agreement when there is no immediate jeopardy
81.56(249A) Duration of remedies
81.57(249A) Termination of provider agreement

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR PERSONS
WITH AN INTELLECTUAL DISABILITY

82.1(249A) Definition
82.2(249A) Licensing and certification
82.3(249A) Conditions of participation for intermediate care facilities for persons with an intellectual disability
82.4 Reserved
82.5(249A) Financial and statistical report
82.6(249A) Eligibility for services
82.7(249A) Initial approval for ICF/ID care

82.8(249A) Determination of need for continued stay
82.9(249A) Arrangements with residents
82.10(249A) Discharge and transfer
82.11 and 82.12 Reserved
82.13(249A) Records
82.14(249A) Payment procedures
82.15(249A) Billing procedures
82.16(249A) Closing of facility
82.17(249A) Audits
82.18(249A) Out-of-state facilities
82.19(249A) State-funded personal needs supplement

CHAPTER 83
MEDICAID WAIVER SERVICES

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

83.1(249A) Definitions
83.2(249A) Eligibility
83.3(249A) Application
83.4(249A) Financial participation
83.5(249A) Redetermination
83.6(249A) Allowable services
83.7(249A) Service plan
83.8(249A) Adverse service actions
83.9(249A) Appeal rights
83.10 to 83.20 Reserved

DIVISION II—HCBS ELDERLY WAIVER SERVICES

83.21(249A) Definitions
83.22(249A) Eligibility
83.23(249A) Application
83.24(249A) Client participation
83.25(249A) Redetermination
83.26(249A) Allowable services
83.27(249A) Service plan
83.28(249A) Adverse service actions
83.29(249A) Appeal rights
83.30(249A) Enhanced services
83.31 to 83.40 Reserved

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

83.41(249A) Definitions
83.42(249A) Eligibility
83.43(249A) Application
83.44(249A) Financial participation
83.45(249A) Redetermination
83.46(249A) Allowable services
83.47(249A) Service plan
83.48(249A) Adverse service actions
83.49(249A) Appeal rights
83.50 to 83.59 Reserved

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

83.60(249A) Definitions
83.61(249A) Eligibility

83.62(249A) Application
83.63(249A) Client participation
83.64(249A) Redetermination
83.65 Reserved
83.66(249A) Allowable services
83.67(249A) Service plan
83.68(249A) Adverse service actions
83.69(249A) Appeal rights
83.70 and 83.71 Reserved
83.72(249A) Rent subsidy program
83.73 to 83.80 Reserved

DIVISION V—BRAIN INJURY WAIVER SERVICES

83.81(249A) Definitions
83.82(249A) Eligibility
83.83(249A) Application
83.84(249A) Client participation
83.85(249A) Redetermination
83.86(249A) Allowable services
83.87(249A) Service plan
83.88(249A) Adverse service actions
83.89(249A) Appeal rights
83.90 to 83.100 Reserved

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

83.101(249A) Definitions
83.102(249A) Eligibility
83.103(249A) Application
83.104(249A) Client participation
83.105(249A) Redetermination
83.106(249A) Allowable services
83.107(249A) Individual service plan
83.108(249A) Adverse service actions
83.109(249A) Appeal rights
83.110 to 83.120 Reserved

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

83.121(249A) Definitions
83.122(249A) Eligibility
83.123(249A) Application
83.124(249A) Financial participation
83.125(249A) Redetermination
83.126(249A) Allowable services
83.127(249A) Service plan
83.128(249A) Adverse service actions
83.129(249A) Appeal rights

CHAPTER 84
EARLY AND PERIODIC SCREENING, DIAGNOSIS, AND TREATMENT

84.1(249A) Definitions
84.2(249A) Eligibility
84.3(249A) Screening services
84.4(249A) Referral
84.5(249A) Follow up

CHAPTER 85
SERVICES IN PSYCHIATRIC INSTITUTIONS

DIVISION I
PSYCHIATRIC HOSPITALS

85.1(249A) Acute care in psychiatric hospitals
85.2(249A) Out-of-state placement
85.3(249A) Eligibility of persons under the age of 21
85.4(249A) Eligibility of persons aged 65 and over
85.5(249A) Client participation
85.6(249A) Responsibilities of hospitals
85.7(249A) Psychiatric hospital reimbursement
85.8(249A,81GA,ch167) Eligibility of persons aged 21 through 64
85.9 to 85.20 Reserved

DIVISION II
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN

85.21(249A) Conditions for participation
85.22(249A) Eligibility of persons under the age of 21
85.23(249A) Client participation
85.24(249A) Responsibilities of facilities
85.25(249A) Reimbursement to psychiatric medical institutions for children
85.26(249A) Outpatient day treatment for persons aged 20 or under
85.27 to 85.40 Reserved

DIVISION III
NURSING FACILITIES FOR PERSONS WITH MENTAL ILLNESS

85.41(249A) Conditions of participation
85.42(249A) Out-of-state placement
85.43(249A) Eligibility of persons aged 65 and over
85.44(249A) Client participation
85.45(249A) Responsibilities of nursing facility
85.46(249A) Policies governing reimbursement
85.47(249A) State-funded personal needs supplement

CHAPTER 86
HEALTHY AND WELL KIDS IN IOWA (HAWK-I) PROGRAM

86.1(514I) Definitions
86.2(514I) Eligibility factors
86.3(514I) Application process
86.4(514I) Coordination with Medicaid
86.5(514I) Effective date of coverage
86.6(514I) Selection of a plan
86.7(514I) Cancellation
86.8(514I) Premiums and copayments
86.9(514I) Annual reviews of eligibility
86.10(514I) Reporting changes
86.11(514I) Notice requirements
86.12(514I) Appeals and fair hearings
86.13(514I) Third-party administrator
86.14(514I) Covered services
86.15(514I) Participating health and dental plans
86.16(514I) Clinical advisory committee
86.17(514I) Use of donations to the HAWK-I program
86.18(505) Health insurance data match program

86.19(514I) Recovery
86.20(514I) Supplemental dental-only coverage

CHAPTER 87
STATE-FUNDED FAMILY PLANNING PROGRAM

87.1(82GA,ch1187) Definitions
87.2(82GA,ch1187) Eligibility
87.3(82GA,ch1187) Application
87.4(82GA,ch1187) Effective date
87.5(82GA,ch1187) Period of eligibility and reapplication
87.6(82GA,ch1187) Reporting changes
87.7(82GA,ch1187) Allocation of funds
87.8(82GA,ch1187) Availability of services
87.9(82GA,ch1187) Payment of covered services
87.10(82GA,ch1187) Submission of claims

CHAPTER 88
SPECIALIZED MANAGED CARE PROGRAMS

DIVISION I
PREPAID HEALTH PLANS

88.1(249A) Definitions
88.2(249A) Participation
88.3(249A) Enrollment
88.4(249A) Disenrollment
88.5(249A) Covered services
88.6(249A) Emergency services
88.7(249A) Access to service
88.8(249A) Grievance procedures
88.9(249A) Records and reports
88.10(249A) Marketing
88.11(249A) Patient education
88.12(249A) Payment to the PHP
88.13(249A) Quality assurance
88.14 to 88.20 Reserved

DIVISION II
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

88.21(249A) Scope and definitions
88.22(249A) PACE organization application and waiver process
88.23(249A) PACE program agreement
88.24(249A) Enrollment and disenrollment
88.25(249A) Program services
88.26(249A) Access to PACE services
88.27(249A) Program administrative requirements
88.28(249A) Payment

CHAPTER 89
DEBTS DUE FROM TRANSFERS OF ASSETS

89.1(249F) Definitions
89.2(249F) Creation of debt
89.3(249F) Exceptions
89.4(249F) Presumption of intent
89.5(249F) Notice of debt
89.6(249F) No timely request of a hearing

89.7(249F) Timely request for a hearing
89.8(249F) Department-requested hearing
89.9(249F) Filing and docketing of the order
89.10(249F) Exemption from Iowa Code chapter 17A

CHAPTER 90
TARGETED CASE MANAGEMENT

90.1(249A) Definitions
90.2(249A) Eligibility
90.3(249A) Determination of need for service
90.4(249A) Application
90.5(249A) Service provision
90.6(249A) Terminating services
90.7(249A) Appeal rights
90.8(249A) Provider requirements

CHAPTER 91
MEDICARE DRUG SUBSIDY

91.1(249A) Definitions
91.2(249A) Application
91.3(249A) Eligibility determination
91.4(249A) Notice of decision
91.5(249A) Effective date
91.6(249A) Changes in circumstances
91.7(249A) Reinvestigation
91.8(249A) Appeals

CHAPTER 92
Reserved

TITLE IX
WORK INCENTIVE DEMONSTRATION

CHAPTER 93
PROMISE JOBS PROGRAM

93.1(239B) Definitions
93.2(239B) Program administration
93.3(239B) Registration and referral
93.4(239B) The family investment agreement (FIA)
93.5(239B) Assessment
93.6(239B) Job readiness and job search activities
93.7(239B) Work activities
93.8(239B) Education and training activities
93.9(239B) Other FIA activities
93.10(239B) Required documentation and verification
93.11(239B) Supportive payments
93.12(239B) Recovery of PROMISE JOBS expense payments
93.13(239B) Resolution of participation issues
93.14(239B) Problems that may provide good cause for participation issues
93.15(239B) Right of appeal
93.16(239B) Resolution of a limited benefit plan
93.17(239B) Worker displacement grievance procedure

CHAPTER 94
Reserved

TITLE X
SUPPORT RECOVERY

CHAPTER 95
COLLECTIONS

95.1(252B)	Definitions
95.2(252B)	Child support recovery eligibility and services
95.3(252B)	Crediting of current and delinquent support
95.4(252B)	Prepayment of support
95.5(252B)	Lump sum settlement
95.6(252B)	Offset against state income tax refund or rebate
95.7(252B)	Offset against federal income tax refund and federal nontax payment
95.8(96)	Child support offset of unemployment insurance benefits
95.9 to 95.11	Reserved
95.12(252B)	Procedures for providing information to consumer reporting agencies
95.13(17A)	Appeals
95.14(252B)	Termination of services
95.15(252B)	Child support recovery unit attorney
95.16(252B)	Handling and use of federal 1099 information
95.17(252B)	Effective date of support
95.18(252B)	Continued services available to canceled family investment program (FIP) or Medicaid recipients
95.19(252B)	Cooperation of public assistance recipients in establishing and obtaining support
95.20(252B)	Cooperation of public assistance applicants in establishing and obtaining support
95.21(252B)	Cooperation in establishing and obtaining support in nonpublic assistance cases
95.22(252B)	Charging pass-through fees
95.23(252B)	Reimbursing assistance with collections of assigned support
95.24(252B)	Child support account
95.25(252B)	Emancipation verification

CHAPTER 96
INFORMATION AND RECORDS

96.1(252B)	Access to information and records from other sources
96.2(252B)	Refusal to comply with written request or subpoena
96.3(252B)	Procedure for refusal
96.4(252B)	Conference conducted
96.5(252B)	Fine assessed
96.6(252B)	Objection to fine or failure to pay

CHAPTER 97
COLLECTION SERVICES CENTER

97.1(252B)	Definitions
97.2(252B)	Transfer of records and payments
97.3(252B)	Support payment records
97.4(252B)	Method of payment
97.5(252D)	Electronic transmission of payments
97.6(252B)	Authorization of payment
97.7(252B)	Processing misdirected payments

CHAPTER 98
SUPPORT ENFORCEMENT SERVICES

DIVISION I
MEDICAL SUPPORT ENFORCEMENT

98.1(252E)	Definitions
98.2(252E)	Provision of services
98.3(252E)	Establishing medical support
98.4(252E)	Accessibility of the health benefit plan
98.5(252E)	Health benefit plan information
98.6(252E)	Insurer authorization
98.7(252E)	Enforcement
98.8(252E)	Contesting the order
98.9 to 98.20	Reserved

DIVISION II
INCOME WITHHOLDING
PART A
DELINQUENT SUPPORT PAYMENTS

98.21(252D)	When applicable
98.22 and 98.23	Reserved
98.24(252D)	Amount of withholding
98.25 to 98.30	Reserved

PART B
IMMEDIATE INCOME WITHHOLDING

98.31(252D)	Effective date
98.32(252D)	Withholding automatic
98.33	Reserved
98.34(252D)	Approval of request for immediate income withholding
98.35(252D)	Modification or termination of withholding
98.36(252D)	Immediate income withholding amounts
98.37(252D)	Immediate income withholding amounts when current support has ended
98.38	Reserved

PART C
INCOME WITHHOLDING—GENERAL PROVISIONS

98.39(252D,252E)	Provisions for medical support
98.40(252D,252E)	Maximum amounts to be withheld
98.41(252D)	Multiple obligations
98.42(252D)	Notice to employer and obligor
98.43(252D)	Contesting the withholding
98.44(252D)	Termination of order
98.45(252D)	Modification of income withholding
98.46(252D)	Refunds of amounts improperly withheld
98.47(252D)	Additional information about hardship
98.48 to 98.50	Reserved

DIVISION III
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

98.51 to 98.60	Reserved

DIVISION IV
PUBLICATION OF NAMES

98.61(252B)	List for publication
98.62(252B)	Releasing the list
98.63 to 98.70	Reserved

DIVISION V
ADMINISTRATIVE SEEK EMPLOYMENT ORDERS

98.71(252B) Seek employment order
98.72(252B) Effective date of order
98.73(252B) Method and requirements of reporting
98.74(252B) Reasons for noncompliance
98.75(252B) Method of service
98.76(252B) Duration of order
98.77 to 98.80 Reserved

DIVISION VI
DEBTOR OFFSET

98.81(252B) Offset against payment owed to a person by a state agency
98.82 to 98.90 Reserved

DIVISION VII
ADMINISTRATIVE LEVY

98.91(252I) Administrative levy
98.92 Reserved
98.93(252I) Verification of accounts
98.94(252I) Notice to financial institution
98.95(252I) Notice to support obligor
98.96(252I) Responsibilities of financial institution
98.97(252I) Challenging the administrative levy
98.98 to 98.100 Reserved

DIVISION VIII
LICENSE SANCTION

98.101(252J) Referral for license sanction
98.102(252J) Reasons for exemption
98.103(252J) Notice of potential sanction of license
98.104(252J) Conference
98.105(252J) Payment agreement
98.106(252J) Staying the process due to full payment of support
98.107(252J) Duration of license sanction
98.108 to 98.120 Reserved

DIVISION IX
EXTERNAL ENFORCEMENT

98.121(252B) Difficult-to-collect arrearages
98.122(252B) Enforcement services by private attorney entitled to state compensation

CHAPTER 99
SUPPORT ESTABLISHMENT AND ADJUSTMENT SERVICES

DIVISION I
CHILD SUPPORT GUIDELINES

99.1(234,252B,252H) Income considered
99.2(234,252B) Allowable deductions
99.3(234,252B) Determining net income
99.4(234,252B) Applying the guidelines
99.5(234,252B) Deviation from guidelines
99.6 to 99.9 Reserved

DIVISION II
PATERNITY ESTABLISHMENT
PART A
JUDICIAL PATERNITY ESTABLISHMENT

99.10(252A)	Temporary support
99.11 to 99.20	Reserved

PART B
ADMINISTRATIVE PATERNITY ESTABLISHMENT

99.21(252F)	When paternity may be established administratively
99.22(252F)	Mother's certified statement
99.23(252F)	Notice of alleged paternity and support debt
99.24(252F)	Conference to discuss paternity and support issues
99.25(252F)	Amount of support obligation
99.26(252F)	Court hearing
99.27(252F)	Paternity contested
99.28(252F)	Paternity test results challenge
99.29(252F)	Agreement to entry of paternity and support order
99.30(252F)	Entry of order establishing paternity only
99.31(252F)	Exception to time limit
99.32(252F)	Genetic test costs assessed
99.33 to 99.35	Reserved

PART C
PATERNITY DISESTABLISHMENT

99.36(598,600B)	Definitions
99.37(598,600B)	Communication between parents
99.38(598,600B)	Continuation of enforcement
99.39(598,600B)	Satisfaction of accrued support
99.40	Reserved

DIVISION III
ADMINISTRATIVE ESTABLISHMENT OF SUPPORT

99.41(252C)	Establishment of an administrative order
99.42 to 99.60	Reserved

DIVISION IV
REVIEW AND ADJUSTMENT OF CHILD SUPPORT OBLIGATIONS

99.61(252B,252H)	Definitions
99.62(252B,252H)	Review of permanent child support obligations
99.63(252B,252H)	Notice requirements
99.64(252B,252H)	Financial information
99.65(252B,252H)	Review and adjustment of a child support obligation
99.66(252B,252H)	Medical support
99.67(252B,252H)	Confidentiality of financial information
99.68(252B,252H)	Payment of service fees and other court costs
99.69(252B,252H)	Denying requests
99.70(252B,252H)	Withdrawing requests
99.71(252H)	Effective date of adjustment
99.72 to 99.80	Reserved

DIVISION V
ADMINISTRATIVE MODIFICATION

99.81(252H)	Definitions
99.82(252H)	Availability of service
99.83(252H)	Modification of child support obligations
99.84(252H)	Notice requirements

99.85(252H) Financial information
99.86(252H) Challenges to the proposed modification action
99.87(252H) Voluntary reduction of income
99.88(252H) Effective date of modification
99.89(252H) Confidentiality of financial information
99.90(252H) Payment of fees
99.91(252H) Denying requests
99.92(252H) Withdrawing requests
99.93 to 99.100 Reserved

DIVISION VI
SUSPENSION AND REINSTATEMENT OF SUPPORT
PART A
SUSPENSION BY MUTUAL CONSENT

99.101(252B) Definitions
99.102(252B) Availability of service
99.103(252B) Basis for suspension of support
99.104(252B) Request for assistance to suspend
99.105(252B) Order suspending support
99.106(252B) Suspension of enforcement of current support

PART B
SUSPENSION BY PAYOR'S REQUEST

99.107(252B) Definitions
99.108(252B) Availability of service
99.109(252B) Basis for suspension of support
99.110(252B) Request for assistance to suspend
99.111(252B) Determining eligibility for suspension
99.112(252B) Order suspending support
99.113(252B) Suspension of enforcement of current support

PART C
REINSTATEMENT OF SUPPORT

99.114(252B) Request for reinstatement
99.115(252B) Reinstatement
99.116(252B) Reinstatement of enforcement of support
99.117(252B) Temporary suspension becomes final

CHAPTER 100
CHILD SUPPORT PARENTAL OBLIGATION PILOT PROJECTS

100.1(17A,80GA,HF667) Definitions
100.2(17A,80GA,HF667) Incentives
100.3(17A,80GA,HF667) Application to be a funded pilot project
100.4(17A,80GA,HF667) Selection of projects
100.5(17A,80GA,HF667) Termination of pilot projects
100.6(17A,80GA,HF667) Reports and records
100.7(17A,80GA,HF667) Appeals
100.8(17A,80GA,HF667) Continued application of rules and sunset provisions

TITLE XI
CHILDREN'S INSTITUTIONS

CHAPTER 101
IOWA JUVENILE HOME

101.1(218) Definitions
101.2(218) Standards
101.3(218) Admission

101.4(218) Plan of care
101.5(218) Communication with individuals
101.6(218) Photographing and recording of individuals
101.7(218) Employment of individual
101.8(218) Temporary home visits
101.9(218) Grievances
101.10(218) Alleged child abuse
101.11(233B) Cost of care
101.12(218) Buildings and grounds
101.13(8,218) Gifts and bequests

CHAPTER 102
Reserved

CHAPTER 103
STATE TRAINING SCHOOL

103.1(218) Definitions
103.2(218) Admission
103.3(218) Plan of care
103.4(218) Communication with individuals
103.5(218) Photographing and recording of individuals
103.6(218) Employment of individual
103.7(218) Temporary home visits
103.8(218) Grievances
103.9(692A) Sex offender registration
103.10(218) Alleged child abuse
103.11(233A) Cost of care
103.12(218) Buildings and grounds
103.13(8,218) Gifts and bequests

CHAPTER 104
Reserved

TITLE XII
LICENSING AND APPROVED STANDARDS

CHAPTER 105
JUVENILE DETENTION
AND SHELTER CARE HOMES

105.1(232) Definitions
105.2(232) Buildings and grounds
105.3(232) Personnel policies
105.4(232) Procedures manual
105.5(232) Staff
105.6(232) Intake procedures
105.7(232) Assessments
105.8(232) Program services
105.9(232) Medication management and administration
105.10(232) Control room—juvenile detention home only
105.11(232) Clothing
105.12(232) Staffings
105.13(232) Child abuse
105.14(232) Daily log
105.15(232) Children's rights

105.16(232) Discipline
105.17(232) Case files
105.18(232) Discharge
105.19(232) Approval
105.20(232) Provisional approval
105.21(232) Mechanical restraint—juvenile detention only
105.22(232) Chemical restraint

CHAPTER 106
CERTIFICATION STANDARDS FOR CHILDREN'S RESIDENTIAL FACILITIES

106.1(237C) Definitions
106.2(237C) Application of the standards
106.3(237C) Application for a certificate of approval
106.4(237C) Certificate of approval
106.5(237C) Denial, suspension, or revocation
106.6(237C) Providing for basic needs
106.7(237C) Educational programs and services
106.8(237C) Protection from mistreatment, physical abuse, sexual abuse, and neglect
106.9(237C) Discipline
106.10(237C) Record checks
106.11(237C) Seclusion and restraints
106.12(237C) Health
106.13(237C) Safety
106.14(237C) Emergencies
106.15(237C) Buildings and physical premises
106.16(237C) Sanitation, water, and waste disposal
106.17(237C) Staffing
106.18(237C) Reports and inspections

CHAPTER 107
CERTIFICATION OF ADOPTION INVESTIGATORS

107.1(600) Introduction
107.2(600) Definitions
107.3(600) Application
107.4(600) Requirements for certification
107.5(600) Granting, denial, or revocation of certification
107.6(600) Certificate
107.7(600) Renewal of certification
107.8(600) Investigative services
107.9(600) International adoptions postplacement report
107.10(600) Retention of adoption records
107.11(600) Reporting of violations
107.12(600) Appeals

CHAPTER 108
LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

108.1(238) Definitions
108.2(238) Licensing procedure
108.3(238) Administration and organization
108.4(238) Staff qualifications
108.5(238) Staffing requirements
108.6(238) Personnel administration
108.7(238) Foster care services

108.8(238) Foster home studies
108.9(238) Adoption services
108.10(238) Supervised apartment living placement services

CHAPTER 109
CHILD CARE CENTERS

109.1(237A) Definitions
109.2(237A) Licensure procedures
109.3(237A) Inspection and evaluation
109.4(237A) Administration
109.5(237A) Parental participation
109.6(237A) Personnel
109.7(237A) Professional growth and development
109.8(237A) Staff ratio requirements
109.9(237A) Records
109.10(237A) Health and safety policies
109.11(237A) Physical facilities
109.12(237A) Activity program requirements
109.13(237A) Extended evening care
109.14(237A) Get-well center
109.15(237A) Food services

CHAPTER 110
CHILD DEVELOPMENT HOMES

110.1(237A) Definitions
110.2(237A) Application for registration
110.3(237A) Renewal of registration
110.4(237A) Compliance checks
110.5(237A) Parental access
110.6(237A) Number of children
110.7(237A) Provider requirements
110.8(237A) Standards
110.9(237A) Files
110.10(237A) Professional development
110.11(234) Registration decision
110.12(237A) Complaints
110.13(237A) Additional requirements for child development home category A
110.14(237A) Additional requirements for child development home category B
110.15(237A) Additional requirements for child development home category C
110.16(237A) Registration actions for nonpayment of child support
110.17(237A) Prohibition from involvement with child care

CHAPTER 111
FAMILY-LIFE HOMES

111.1(249) Definitions
111.2(249) Application for certification
111.3(249) Provisions pertaining to the certificate
111.4(249) Physical standards
111.5(249) Personal characteristics of family-life home family
111.6(249) Health of family
111.7(249) Planned activities and personal effects
111.8(249) Client eligibility
111.9(249) Medical examinations, records, and care of a client

111.10(249) Placement agreement
111.11(249) Legal liabilities
111.12(249) Emergency care and release of client
111.13(249) Information about client to be confidential

CHAPTER 112
LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

112.1(237) Applicability
112.2(237) Definitions
112.3(237) Application for license
112.4(237) License
112.5(237) Denial
112.6(237) Revocation
112.7(237) Provisional license
112.8(237) Adverse actions
112.9(237) Suspension
112.10(232) Mandatory reporting of child abuse
112.11(237) Required training on the reasonable and prudent parent standard

CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

113.1(237) Applicability
113.2(237) Definitions
113.3(237) Licensing procedure
113.4(237) Provisions pertaining to the license
113.5(237) Physical standards
113.6(237) Sanitation, water, and waste disposal
113.7(237) Safety
113.8(237) Foster parent training
113.9(237) Involvement of kin
113.10(237) Information on the foster child
113.11(237) Health of foster family
113.12(237) Characteristics of foster parents
113.13(237) Record checks
113.14(237) Reference checks
113.15(237) Unannounced visits
113.16(237) Planned activities and personal effects
113.17(237) Medical examinations and health care of the child
113.18(237) Training and discipline of foster children
113.19(237) Emergency care and release of children
113.20(237) Changes in foster family home

CHAPTER 114
LICENSING AND REGULATION OF ALL
GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

114.1(237) Applicability
114.2(237) Definitions
114.3(237) Physical standards
114.4(237) Sanitation, water, and waste disposal
114.5(237) Safety
114.6(237) Organization and administration
114.7(237) Policies and record-keeping requirements
114.8(237) Staff

114.9(237) Intake procedures
114.10(237) Program services
114.11(237) Case files
114.12(237) Drug utilization and control
114.13(237) Children's rights
114.14(237) Personal possessions
114.15(237) Religion—culture
114.16(237) Work or vocational experiences
114.17(237) Family involvement
114.18(237) Children's money
114.19(237) Child abuse
114.20(237) Discipline
114.21(237) Illness, accident, death, or absence from the facility
114.22(237) Records
114.23(237) Unannounced visits
114.24(237) Standards for private juvenile shelter care and detention homes

CHAPTER 115
LICENSING AND REGULATION OF
COMPREHENSIVE RESIDENTIAL FACILITIES FOR CHILDREN

115.1(237) Applicability
115.2(237) Definitions
115.3(237) Information upon admission
115.4(237) Staff
115.5(237) Program services
115.6(237) Restraints
115.7(237) Control room
115.8(237) Locked cottages
115.9(237) Mechanical restraint
115.10(237) Chemical restraint

CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES
FOR CHILDREN WITH AN INTELLECTUAL DISABILITY

116.1(237) Applicability
116.2(237) Definitions
116.3(237) Qualifications of staff
116.4(237) Staff to client ratio
116.5(237) Program components
116.6(237) Restraint

CHAPTER 117
FOSTER PARENT TRAINING

117.1(237) Required preservice training
117.2(237) Required orientation
117.3(237) Application materials for in-service training
117.4(237) Application process for in-service training
117.5(237) Application decisions
117.6(237) Application conference available
117.7(237) Required in-service training
117.8(237) Specific in-service training required
117.9(237) Foster parent training expenses

CHAPTER 118
CHILD CARE QUALITY RATING SYSTEM

118.1(237A) Definitions
118.2(237A) Application for quality rating
118.3(237A) Rating standards for child care centers and preschools (sunsetting on July 31, 2011)
118.4(237A) Rating criteria for child development homes (sunsetting on July 31, 2011)
118.5(237A) Rating standards for child care centers, preschools, and programs operating under the authority of an accredited school district or nonpublic school
118.6(237A) Rating criteria for child development homes
118.7(237A) Award of quality rating
118.8(237A) Adverse actions

CHAPTER 119
RECORD CHECK EVALUATIONS FOR
CERTAIN EMPLOYERS AND EDUCATIONAL TRAINING PROGRAMS

119.1(135B,135C) Definitions
119.2(135B,135C) When record check evaluations are requested
119.3(135C) Request for evaluation
119.4(135B,135C) Completion of evaluation
119.5(135B,135C) Appeal rights

CHAPTER 120
CHILD CARE HOMES

120.1(237A) Definitions
120.2(237A) Application for payment
120.3(237A) Renewal of agreement
120.4(237A) Compliance checks
120.5(237A) Parental access
120.6(237A) Number of children
120.7(237A) Provider requirements
120.8(237A) Standards
120.9(237A) Children's files
120.10(237A) Professional development
120.11(237A) Child care assistance provider agreement decision
120.12(237A) Complaints
120.13(237A) Prohibition from involvement with child care

CHAPTERS 121 to 129
Reserved

TITLE XIII
SERVICE ADMINISTRATION

CHAPTER 130
GENERAL PROVISIONS

130.1(234) Definitions
130.2(234) Application
130.3(234) Eligibility
130.4(234) Fees
130.5(234) Adverse service actions
130.6(234) Social casework
130.7(234) Case plan
130.8 Reserved
130.9(234) Entitlement

CHAPTER 131
SOCIAL CASEWORK

131.1(234) Definitions
131.2(234) Eligibility
131.3(234) Service provision
131.4 Reserved
131.5(234) Adverse actions

CHAPTER 132
Reserved

CHAPTER 133
IV-A EMERGENCY ASSISTANCE PROGRAM

133.1(235) Definitions
133.2(235) Application
133.3(235) Eligibility
133.4(235) Method of service provision
133.5(235) Duration of services
133.6(235) Discontinuance of the program

CHAPTERS 134 to 141
Reserved

CHAPTER 142
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

142.1(232) Compact agreement
142.2(232) Compact administrator
142.3(232) Article II(d)
142.4(232) Article III(a)
142.5(232) Article III(a) procedures
142.6(232) Article III(c)
142.7(232) Article VIII(a)
142.8(232) Applicability
142.9(232) NEICE database

CHAPTER 143
INTERSTATE COMPACT ON JUVENILES

143.1(232) Compact agreement
143.2(232) Compact administrator
143.3(232) Sending a juvenile out of Iowa under the compact
143.4(232) Receiving cases in Iowa under the interstate compact
143.5(232) Runaways

CHAPTERS 144 to 149
Reserved

TITLE XIV
GRANT/CONTRACT/PAYMENT ADMINISTRATION

CHAPTER 150
Reserved

CHAPTER 151
JUVENILE COURT SERVICES DIRECTED PROGRAMS

DIVISION I
GENERAL PROVISIONS

151.1(232)	Definitions
151.2(232)	Administration of funds for court-ordered services and graduated sanction services
151.3(232)	Administration of juvenile court services programs within each judicial district
151.4(232)	Billing and payment
151.5(232)	Appeals
151.6(232)	District program reviews and audits
151.7 to 151.19	Reserved

DIVISION II
COURT-ORDERED SERVICES

151.20(232)	Juvenile court services responsibilities
151.21(232)	Certification process
151.22(232)	Expenses
151.23 to 151.29	Reserved

DIVISION III
GRADUATED SANCTION SERVICES

151.30(232)	Community-based interventions
151.31(232)	School-based supervision
151.32(232)	Supportive enhancements
151.33	Reserved
151.34(232)	Administration of graduated sanction services
151.35(232)	Contract development for graduated sanction services

CHAPTER 152
FOSTER CARE CONTRACTING

152.1(234)	Definitions
152.2(234)	Conditions of participation
152.3(234)	Provider reviews
152.4(234)	Sanctions against providers
152.5(234)	Adverse actions

CHAPTER 153
FUNDING FOR LOCAL SERVICES

DIVISION I
SOCIAL SERVICES BLOCK GRANT

153.1(234)	Definitions
153.2(234)	Development of preexpenditure report
153.3(234)	Amendment to preexpenditure report
153.4(234)	Service availability
153.5(234)	Allocation of block grant funds
153.6 and 153.7	Reserved
153.8(234)	Expenditure of supplemental funds
153.9 and 153.10	Reserved

DIVISION II
DECATEGORIZATION OF CHILD WELFARE AND JUVENILE JUSTICE FUNDING

153.11(232)	Definitions
153.12(232)	Implementation requirements
153.13(232)	Role and responsibilities of decategorization project governance boards
153.14(232)	Realignment of decategorization project boundaries

153.15(232) Decategorization services funding pool
153.16(232) Relationship of decategorization funding pool to other department child welfare funding
153.17(232) Relationship of decategorization funding pool to juvenile court services funding streams
153.18(232) Requirements for annual services plan
153.19(232) Requirements for annual progress report
153.20 to 153.30 Reserved

DIVISION III
MENTAL ILLNESS, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES—LOCAL SERVICES

153.31 to 153.50 Reserved

DIVISION IV
STATE PAYMENT PROGRAM FOR LOCAL MENTAL HEALTH, MENTAL RETARDATION, AND
DEVELOPMENTAL DISABILITIES SERVICES TO ADULTS WITHOUT LEGAL SETTLEMENT

153.51(331) Definitions
153.52(331) Eligibility requirements
153.53(331) Application procedure
153.54(331) Eligibility determination
153.55(331) Eligible services
153.56(331) Program administration
153.57(331) Reduction, denial, or termination of benefits
153.58(331) Appeals

CHAPTER 154
Reserved

CHAPTER 155
CHILD ABUSE PREVENTION PROGRAM

155.1(235A) Definitions
155.2(235A) Contract for program administration
155.3(235A) Awarding of grants

CHAPTER 156
PAYMENTS FOR FOSTER CARE

156.1(234) Definitions
156.2(234) Foster care recovery
156.3 to 156.5 Reserved
156.6(234) Rate of maintenance payment for foster family care
156.7 Reserved
156.8(234) Additional payments
156.9(234) Rate of payment for foster group care
156.10(234) Payment for reserve bed days
156.11(234) Emergency juvenile shelter care payment
156.12(234) Supervised apartment living
156.13 Reserved
156.14(234,252C) Voluntary placements
156.15(234) Child's earnings
156.16(234) Trust funds and investments
156.17(234) Preadoptive homes
156.18 and 156.19 Reserved
156.20(234) Eligibility for foster care payment

CHAPTER 157
Reserved

CHAPTER 158
FOSTER HOME INSURANCE FUND

158.1(237) Payments from the foster home insurance fund
158.2(237) Payment limits
158.3(237) Claim procedures
158.4(237) Time frames for filing claims
158.5(237) Appeals

CHAPTER 159
CHILD CARE RESOURCE AND REFERRAL SERVICES

159.1(237A) Definitions
159.2(237A) Availability of funds
159.3(237A) Participation requirements
159.4(237A) Request for proposals for project grants
159.5(237A) Selection of proposals

CHAPTER 160
ADOPTION OPPORTUNITY GRANT PROGRAM

160.1(234) Definitions
160.2(234) Availability of grant funds
160.3(234) Project eligibility
160.4(234) Request for proposals for project grants
160.5(234) Selection of proposals
160.6(234) Project contracts
160.7(234) Records
160.8(234) Evaluation of projects
160.9(234) Termination
160.10(234) Appeals

CHAPTER 161
IOWA SENIOR LIVING TRUST FUND

161.1(249H) Definitions
161.2(249H) Funding and operation of trust fund
161.3(249H) Allocations from the senior living trust fund
161.4(249H) Participation by government-owned nursing facilities

CHAPTER 162
NURSING FACILITY CONVERSION
AND LONG-TERM CARE SERVICES
DEVELOPMENT GRANTS

162.1(249H) Definitions
162.2(249H) Availability of grants
162.3(249H) Grant eligibility
162.4(249H) Grant application process
162.5(249H) Grant dispersal stages
162.6(249H) Project contracts
162.7(249H) Grantee responsibilities
162.8(249H) Offset
162.9(249H) Appeals

CHAPTER 163
ADOLESCENT PREGNANCY PREVENTION AND SERVICES
TO PREGNANT AND PARENTING ADOLESCENTS
PROGRAMS

163.1(234) Definitions
163.2(234) Availability of grants for projects
163.3(234) Project eligibility
163.4(234) Request for proposals for pilot project grants
163.5(234) Selection of proposals
163.6(234) Project contracts
163.7(234) Records
163.8(234) Evaluation
163.9(234) Termination of contract
163.10(234) Appeals

CHAPTER 164
IOWA HOSPITAL TRUST FUND

164.1(249I) Definitions
164.2(249I) Funding and operation of trust fund
164.3(249I) Allocations from the hospital trust fund
164.4(249I) Participation by public hospitals

CHAPTER 165
Reserved

CHAPTER 166
QUALITY IMPROVEMENT INITIATIVE GRANTS

166.1(249A) Definitions
166.2(249A) Availability of grants
166.3(249A) Requirements for applicants
166.4(249A) Requirements for initiatives
166.5(249A) Applications
166.6(249A) Awarding of grants
166.7(249A) Grant requirements

CHAPTER 167
JUVENILE DETENTION REIMBURSEMENT

DIVISION I
ANNUAL REIMBURSEMENT PROGRAM

167.1(232) Definitions
167.2(232) Availability of funds
167.3(232) Eligible facilities
167.4(232) Available reimbursement
167.5(232) Submission of voucher
167.6(232) Reimbursement by the department

CHAPTER 168
CHILD CARE EXPANSION PROGRAMS

168.1(234) Definitions
168.2(234) Availability of funds
168.3(234) Eligibility requirements
168.4(234) Request for proposals
168.5(234) Selection of proposals

168.6(234) Appeals
168.7(234) Contracts
168.8(234) Reporting requirements
168.9(234) Termination of contract

CHAPTER 169
Reserved

TITLE XV
INDIVIDUAL AND FAMILY SUPPORT AND PROTECTIVE SERVICES

CHAPTER 170
CHILD CARE SERVICES

170.1(237A) Definitions
170.2(237A,239B) Eligibility requirements
170.3(237A,239B) Application and determination of eligibility
170.4(237A) Elements of service provision
170.5(237A) Adverse actions
170.6(237A) Appeals
170.7(237A) Provider fraud
170.8 Reserved
170.9(237A) Child care assistance overpayments

CHAPTER 171
Reserved

CHAPTER 172
FAMILY-CENTERED CHILD WELFARE SERVICES

DIVISION I
GENERAL PROVISIONS

172.1(234) Definitions
172.2(234) Purpose and scope
172.3(234) Authorization
172.4(234) Reimbursement
172.5(234) Client appeals
172.6(234) Reviews and audits
172.7 to 172.9 Reserved

DIVISION II
SAFETY PLAN SERVICES

172.10(234) Service requirements
172.11(234) Contractor selection
172.12(234) Service eligibility
172.13(234) Service components
172.14(234) Monitoring of service delivery
172.15(234) Billing and payment
172.16 to 172.19 Reserved

DIVISION III
FAMILY SAFETY, RISK, AND PERMANENCY SERVICES

172.20(234) Service requirements
172.21(234) Contractor selection
172.22(234) Service eligibility
172.23(234) Service components
172.24(234) Monitoring of service delivery

172.25(234) Billing and payment
172.26 to 172.29 Reserved

DIVISION IV
FAMILY-CENTERED SUPPORTIVE SERVICES

172.30(234) Service components
172.31(234) Contractor selection
172.32(234) Service eligibility
172.33(234) Monitoring of service delivery
172.34(234) Billing and payment

CHAPTERS 173 and 174
Reserved

CHAPTER 175
ABUSE OF CHILDREN

DIVISION I
CHILD ABUSE

175.1 to 175.20 Reserved

DIVISION II
CHILD ABUSE ASSESSMENT

175.21(232,235A) Definitions
175.22(232) Receipt of a report of suspected child abuse
175.23(232) Sources of report of suspected child abuse
175.24(232) Assessment intake process
175.25(232) Assessment process
175.26(232) Completion of a written assessment report
175.27(232) Contact with juvenile court or the county attorney
175.28(232) Consultation with health practitioners or mental health professionals
175.29(232) Consultation with law enforcement
175.30(232) Information shared with law enforcement
175.31(232) Completion of required correspondence
175.32(232,235A) Case records
175.33(232,235A) Child protection centers
175.34(232) Department-operated facilities
175.35(232,235A) Jurisdiction of assessments
175.36(235A) Multidisciplinary teams
175.37(232) Community education
175.38(235) Written authorizations
175.39(232) Founded child abuse
175.40 Reserved
175.41(235A) Access to child abuse information
175.42(235A) Person conducting research
175.43(235A) Child protection services citizen review panels

CHAPTER 176
DEPENDENT ADULT ABUSE

176.1(235B) Definitions
176.2(235B) Denial of critical care
176.3(235B) Appropriate evaluation
176.4(235B) Reporters
176.5(235B) Reporting procedure
176.6(235B) Duties of the department upon receipt of report

176.7(235B) Appropriate evaluation or assessment
176.8(235B) Immunity from liability for reporters
176.9(235B) Registry records
176.10(235B) Adult abuse information disseminated
176.11(235B) Person conducting research
176.12(235B) Examination of information
176.13(235B) Dependent adult abuse information registry
176.14 Reserved
176.15(235B) Multidisciplinary teams
176.16(235B) Medical and mental health examinations
176.17(235B) Request for correction or expungement

CHAPTER 177
IN-HOME HEALTH RELATED CARE

177.1(249) In-home health related care
177.2(249) Own home
177.3(249) Service criteria
177.4(249) Eligibility
177.5(249) Providers of health care services
177.6(249) Health care plan
177.7(249) Client participation
177.8(249) Determination of reasonable charges
177.9(249) Written agreements
177.10(249) Emergency services
177.11(249) Termination

CHAPTERS 178 to 183
Reserved

CHAPTER 184
INDIVIDUAL AND FAMILY DIRECT SUPPORT

DIVISION I
FAMILY SUPPORT SUBSIDY PROGRAM

184.1(225C) Definitions
184.2(225C) Eligibility requirements
184.3(225C) Application process
184.4(225C) Family support services plan
184.5 Reserved
184.6(225C) Amount of subsidy payment
184.7(225C) Redetermination of eligibility
184.8(225C) Termination of subsidy payments
184.9(225C) Appeals
184.10 to 184.20 Reserved

DIVISION II
COMPREHENSIVE FAMILY SUPPORT PROGRAM

184.21(225C) Definitions
184.22(225C) Eligibility
184.23(225C) Application
184.24(225C) Contractor selection and duties
184.25(225C) Direct assistance
184.26(225C) Appeals
184.27(225C) Parent advisory council

CHAPTER 185
Reserved

CHAPTER 186
COMMUNITY CARE

186.1(234) Definitions
186.2(234) Eligibility
186.3(234) Services provided
186.4(234) Appeals

CHAPTER 187
AFTERCARE SERVICES PROGRAM

DIVISION I
AFTERCARE SERVICES

187.1(234) Purpose
187.2(234) Aftercare services program eligibility requirements
187.3(234) Services and supports provided
187.4(234) Termination
187.5(234) Waiting list
187.6(234) Administration
187.7 to 187.9 Reserved

DIVISION II
PREPARATION FOR ADULT LIVING (PAL) PROGRAM COMPONENT

187.10(234) Purpose
187.11(234) PAL program component eligibility requirements
187.12(234) Payment
187.13(234) Termination of stipend
187.14(234) Waiting list
187.15(234) Administration

CHAPTERS 188 to 199
Reserved

TITLE XVI
ALTERNATIVE LIVING

CHAPTER 200
ADOPTION SERVICES

200.1(600) Definitions
200.2(600) Release of custody services
200.3(600) Application
200.4(600) Adoption services
200.5(600) Termination of parental rights
200.6 and 200.7 Reserved
200.8(600) Interstate placements
200.9 Reserved
200.10(600) Requests for home studies
200.11(600) Reasons for denial
200.12(600) Removal of child from preadoptive family
200.13(600) Consents
200.14(600) Requests for access to information for research or treatment
200.15(600) Requests for information for purposes other than research or treatment
200.16(600) Appeals

CHAPTER 201
SUBSIDIZED ADOPTIONS

201.1(600) Administration
201.2(600) Definitions
201.3(600) Conditions of eligibility or ineligibility
201.4(600) Application
201.5(600) Negotiation of amount of presubsidy or subsidy
201.6(600) Types of subsidy
201.7(600) Termination of subsidy
201.8(600) Reinstatement of subsidy
201.9(600) New application
201.10(600) Medical assistance based on residency
201.11(600) Presubsidy recovery

CHAPTER 202
FOSTER CARE PLACEMENT AND SERVICES

202.1(234) Definitions
202.2(234) Eligibility
202.3(234) Voluntary placements
202.4(234) Selection of facility
202.5(234) Preplacement
202.6(234) Placement
202.7(234) Out-of-area placements
202.8(234) Out-of-state placements
202.9(234) Supervised apartment living
202.10(234) Services to foster parents
202.11(234) Services to the child
202.12(234) Services to parents
202.13(234) Removal of the child
202.14(234) Termination
202.15(234) Case permanency plan
202.16(135H) Department approval of need for a psychiatric medical institution for children
202.17(232) Area group care targets
202.18(235) Local transition committees

CHAPTER 203
IOWA ADOPTION EXCHANGE

203.1(232) Definitions
203.2(232) Children to be registered on the exchange system
203.3(232) Families to be registered on the exchange system
203.4(232) Matching process

CHAPTER 204
SUBSIDIZED GUARDIANSHIP PROGRAM

204.1(234) Definitions
204.2(234) Eligibility
204.3(234) Application
204.4(234) Negotiation of amount of subsidy
204.5(234) Parental liability
204.6(234) Termination of subsidy
204.7(234) Reinstatement of subsidy
204.8(234) Appeals
204.9(234) Medical assistance

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	$34
165% of Federal Poverty Level	$47
180% of Federal Poverty Level	$56
200% of Federal Poverty Level	$66
225% of Federal Poverty Level	$77
250% of Federal Poverty Level	$89
300% of Federal Poverty Level	$112
350% of Federal Poverty Level	$137
400% of Federal Poverty Level	$161
450% of Federal Poverty Level	$186
550% of Federal Poverty Level	$232
650% of Federal Poverty Level	$280
750% of Federal Poverty Level	$329
850% of Federal Poverty Level	$389
1000% of Federal Poverty Level	$467
1150% of Federal Poverty Level	$547
1300% of Federal Poverty Level	$631
1480% of Federal Poverty Level	$729
1530% of Federal Poverty Level	$746
1590% of Federal Poverty Level	$778
1660% of Federal Poverty Level	$812
1740% of Federal Poverty Level	$852

(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; **ARC 2557C**, IAB 6/8/16, effective 8/1/16; **ARC 3094C**, IAB 6/7/17, effective 8/1/17]

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 Private 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 no longer provides health 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; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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, 2017, through June 30, 2018, this average statewide cost shall be $6,269.63 per month or $206.24 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; **ARC 2605C**, IAB 7/6/16, effective 7/1/16; **ARC 3183C**, IAB 7/5/17, effective 7/1/17]

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, 2017, to June 30, 2018, shall be as follows:

(1) The average statewide charge to a private-pay resident of a nursing facility is $5,829 per month.

(2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is $29,240 per month.

(3) The average statewide charge to a resident of a mental health institute is $29,312 per month.

(4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is $7,999 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; **ARC 2605C**, IAB 7/6/16, effective 7/1/16; **ARC 3182C**, IAB 7/5/17, effective 7/1/17; **ARC 3183C**, IAB 7/5/17, effective 7/1/17]

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 services are ones which are otherwise not covered under Medicaid, the bill is for a responsible relative who is not in the Medicaid-eligible group or the bill is for services delivered before the start of a certification period.

"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; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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

a. Definitions.

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

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

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

b. 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 investment 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 249A.53(2).

(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; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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. Rescinded **ARC 2361C**, IAB 1/6/16, effective 1/1/16.

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

[**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]

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

[Filed 3/11/70; amended 12/17/73, 5/16/74, 7/1/74]
[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]
[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 1/31/77, Notice 12/1/76—published 2/23/77, effective 3/30/77]
[Filed 4/13/77, Notice 11/3/76—published 5/4/77, effective 6/8/77]
[Filed emergency 6/22/77—published 7/13/77, effective 7/1/77]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
[Filed emergency 7/28/78 after Notice 4/19/78—published 8/23/78, effective 7/28/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed 2/2/79, Notice 12/27/78—published 2/21/79, effective 3/28/79]
[Filed 6/5/79, Notice 4/4/79—published 6/27/79, effective 8/1/79]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]
[Filed emergency 5/5/80—published 5/28/80, effective 5/5/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed without Notice 9/25/80—published 10/15/80, effective 12/1/80]
[Filed 12/19/80, Notice 10/15/80—published 1/7/81, effective 2/11/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed 9/25/81, Notice 7/22/81—published 10/14/81, effective 11/18/81]

[Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
[Filed 1/28/82, Notice 12/9/81—published 2/17/82, effective 4/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 6/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
[Filed emergency 7/30/82—published 8/18/82, effective 8/1/82]
[Filed 9/23/82, Notices 6/9/82, 8/4/82—published 10/13/82, effective 12/1/82]
[Filed emergency 3/18/83—published 4/13/83, effective 4/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 9/26/83—published 10/12/83, effective 10/1/83]
[Filed 10/28/83, Notice 9/14/83—published 11/23/83, effective 1/1/84]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 12/16/83, Notice 11/9/83—published 1/4/84, effective 2/8/84]
[Filed emergency 1/13/84—published 2/1/84, effective 2/8/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed emergency 9/28/84—published 10/24/84, effective 10/1/84]
[Filed emergency 1/17/85—published 2/13/85, effective 1/17/85]
[Filed without Notice 1/22/85—published 2/13/85, effective 4/1/85]
[Filed emergency 3/22/85—published 4/10/85, effective 4/1/85]
[Filed 3/22/85, Notice 2/13/85—published 4/10/85, effective 6/1/85]
[Filed 4/29/85, Notice 10/24/84—published 5/22/85, effective 7/1/85]
[Filed 10/1/85, Notice 7/31/85—published 10/23/85, effective 12/1/85]
[Filed 2/21/86, Notice 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 3/21/86 after Notice 2/12/86—published 4/9/86, effective 4/1/86]
[Filed emergency 4/28/86—published 5/21/86, effective 5/1/86]
[Filed emergency 8/28/86—published 9/24/86, effective 9/1/86]
[Filed 9/5/86, Notice 6/18/86—published 9/24/86, effective 11/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed without Notice 1/15/87—published 2/11/87, effective 4/1/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed 3/26/87, Notice 2/11/87—published 4/22/87, effective 6/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed emergency 5/29/87 after Notice 4/22/87—published 6/17/87, effective 7/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed emergency after Notice 9/24/87, Notice 8/12/87—published 10/21/87, effective 10/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed emergency after Notice 10/23/87, Notice 9/9/87—published 11/18/87, effective 11/1/87]
[Filed 10/23/87, Notice 9/9/87—published 11/18/87, effective 1/1/88]
[Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
[Filed emergency 3/16/88—published 4/6/88, effective 3/16/88]
[Filed 3/17/88, Notice 1/13/88—published 4/6/88, effective 6/1/88]
[Filed emergency 4/22/88—published 5/18/88, effective 5/1/88]
[Filed 4/22/88, Notice 3/9/88—published 5/18/88, effective 7/1/88]
[Filed 6/9/88, Notice 4/20/88—published 6/29/88, effective 9/1/88]
[Filed 8/4/88, Notices 6/29/88◊—published 8/24/88, effective 10/1/88]
[Filed without Notice 9/21/88—published 10/19/88, effective 12/1/88]
[Filed 10/27/88, Notice 8/24/88—published 11/16/88, effective 1/1/89]
[Filed emergency 11/14/88—published 11/30/88, effective 11/14/88]
[Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]
[Filed emergency 4/13/89 after Notice 3/8/89—published 5/3/89, effective 5/1/89]
[Filed 4/13/89, Notice 2/22/89—published 5/3/89, effective 7/1/89]
[Filed 5/10/89, Notice 4/5/89—published 5/31/89, effective 8/1/89]

[Filed emergency 6/9/89 after Notice 5/3/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 10/10/89—published 11/1/89, effective 12/1/89]
[Filed 10/10/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
[Filed 12/19/89, Notice 11/1/89—published 1/10/90, effective 3/1/90]
[Filed emergency 1/10/90—published 2/7/90, effective 1/10/90]
[Filed 1/16/90, Notice 11/15/89—published 2/7/90, effective 4/1/90]
[Filed emergency 2/16/90—published 3/7/90, effective 4/1/90]
[Filed without Notice 2/16/90—published 3/7/90, effective 5/1/90]
[Filed emergency 3/14/90—published 4/4/90, effective 3/14/90]
[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 6/1/90]
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
[Filed emergency 6/13/90—published 7/11/90, effective 6/14/90]
[Filed emergency 6/20/90 after Notice 4/18/90—published 7/11/90, effective 7/1/90]
[Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
[Filed emergency 8/16/90 after Notice of 6/27/90—published 9/5/90, effective 10/1/90]
[Filed 8/16/90, Notices 6/13/90, 7/11/90—published 9/5/90, effective 11/1/90]
[Filed emergency 12/13/90—published 1/9/91, effective 1/1/91]
[Filed 2/14/91, Notice 1/9/91—published 3/6/91, effective 5/1/91]
[Filed emergency 3/14/91—published 4/3/91, effective 3/14/91]
[Filed 3/14/91, Notice 1/23/91—published 4/3/91, effective 6/1/91]
[Filed emergency 4/11/91—published 5/1/91, effective 4/11/91]
[Filed 4/11/91, Notice 2/20/91—published 5/1/91, effective 7/1/91]
[Filed emergency 5/17/91 after Notice 4/3/91—published 6/12/91, effective 7/1/91]
[Filed 5/17/91, Notices 4/3/90◊—published 6/12/91, effective 8/1/91]
[Filed emergency 6/14/91 after Notice 5/1/91—published 7/10/91, effective 7/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]
[Filed emergency 9/18/91 after Notice 4/17/91—published 10/16/91, effective 10/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 12/11/91—published 1/8/92, effective 1/1/92]
[Filed emergency 12/11/91 after Notice 10/30/91—published 1/8/92, effective 1/1/92]
[Filed 12/11/92, Notice 10/16/91—published 1/8/92, effective 3/1/92][1]
[Filed 1/15/92, Notice 11/13/91—published 2/5/92, effective 4/1/92]
[Filed 2/13/92, Notices 1/8/92◊—published 3/4/92, effective 5/1/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 4/16/92 after Notice 2/19/92—published 5/13/92, effective 5/1/92]
[Filed emergency 5/14/92 after Notice 3/18/92—published 6/10/92, effective 7/1/92]
[Filed 5/14/92, Notices 3/18/92◊—published 6/10/92, effective 8/1/92]
[Filed 6/11/92, Notice 4/29/92—published 7/8/92, effective 9/1/92]
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed emergency 12/1/92—published 12/23/92, effective 1/1/93]
[Filed emergency 1/14/93 after Notice 10/28/92—published 2/3/93, effective 2/1/93]
[Filed 1/14/93, Notices 10/28/92, 11/25/92, 12/9/92—published 2/3/93, effective 4/1/93]
[Filed 2/10/93, Notice 12/23/92—published 3/3/93, effective 5/1/93]
[Filed 4/15/93, Notice 2/17/93—published 5/12/93, effective 7/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed emergency 6/11/93 after Notice 4/28/93—published 7/7/93, effective 7/1/93]

[Filed 7/14/93, Notice 5/12/93—published 8/4/93, effective 10/1/93]
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 9/17/93—published 10/13/93, effective 10/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
[Filed emergency 11/12/93—published 12/8/93, effective 1/1/94]
[Filed emergency 12/16/93—published 1/5/94, effective 1/1/94]
[Filed without Notice 12/16/93—published 1/5/94, effective 2/9/94]
[Filed 12/16/93, Notices 10/13/93, 10/27/93—published 1/5/94, effective 3/1/94]
[Filed 2/10/94, Notices 12/8/93, 1/5/94◊—published 3/2/94, effective 5/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
[Filed 5/11/94, Notice 3/16/94—published 6/8/94, effective 8/1/94]
[Filed 6/16/94, Notice 4/27/94—published 7/6/94, effective 9/1/94]
[Filed 9/15/94, Notice 8/3/94—published 10/12/94, effective 11/16/94]
[Filed 10/12/94, Notice 8/17/94—published 11/9/94, effective 1/1/95]
[Filed emergency 12/15/94—published 1/4/95, effective 1/1/95]
[Filed 12/15/94, Notices 10/26/94, 11/9/94—published 1/4/95, effective 3/1/95]
[Filed 2/16/95, Notices 11/23/94, 12/21/94, 1/4/95—published 3/15/95, effective 5/1/95]
[Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
[Filed emergency 9/25/95—published 10/11/95, effective 10/1/95]
[Filed 11/16/95, Notices 9/27/95, 10/11/95—published 12/6/95, effective 2/1/96]
[Filed emergency 12/12/95—published 1/3/96, effective 1/1/96]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
[Filed 2/14/96, Notice 1/3/96—published 3/13/96, effective 5/1/96]
[Filed 4/10/96, Notice 2/14/96—published 5/8/96, effective 7/1/96]
[Filed emergency 9/19/96—published 10/9/96, effective 9/19/96]
[Filed 10/9/96, Notice 8/28/96—published 11/6/96, effective 1/1/97]
[Filed emergency 12/12/96—published 1/1/97, effective 1/1/97]◊
[Filed 12/12/96, Notices 9/11/96, 10/9/96—published 1/1/97, effective 3/1/97]
[Filed 2/12/97, Notice 1/1/97—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notice 1/1/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/26/97—published 5/7/97, effective 7/1/97]
[Filed emergency 9/16/97—published 10/8/97, effective 10/1/97]
[Filed 9/16/97, Notice 7/16/97—published 10/8/97, effective 12/1/97]
[Filed emergency 12/10/97—published 12/31/97, effective 1/1/98]
[Filed emergency 12/10/97 after Notices 10/22/97, 11/5/97—published 12/31/97, effective 1/1/98]
[Filed emergency 1/14/98 after Notice 11/19/97—published 2/11/98, effective 2/1/98]
[Filed 2/11/98, Notice 12/31/97—published 3/11/98, effective 5/1/98]◊
[Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed emergency 6/25/98—published 7/15/98, effective 7/1/98]
[Filed 7/15/98, Notices 6/3/98—published 8/12/98, effective 10/1/98]
[Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
[Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
[Filed emergency 12/9/98—published 12/30/98, effective 1/1/99]
[Filed 2/10/99, Notice 12/30/98—published 3/10/99, effective 4/15/99]
[Filed 3/10/99, Notice 11/18/98—published 4/7/99, effective 6/1/99]
[Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 7/1/99]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed 5/14/99, Notice 4/7/99—published 6/2/99, effective 8/1/99]

[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 6/10/99, Notice 4/21/99—published 6/30/99, effective 9/1/99]
[Filed emergency 8/12/99 after Notice 6/16/99—published 9/8/99, effective 9/1/99]
[Filed 8/11/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed emergency 11/10/99 after Notice 10/6/99—published 12/1/99, effective 12/1/99]
[Filed emergency 12/8/99—published 12/29/99, effective 1/1/00]
[Filed 12/8/99, Notice 11/3/99—published 12/29/99, effective 2/2/00]
[Filed 12/8/99, Notice 10/6/99—published 12/29/99, effective 3/1/00]
[Filed 2/9/00, Notice 12/29/99—published 3/8/00, effective 5/1/00]◊
[Filed emergency 3/8/00—published 4/5/00, effective 4/1/00]
[Filed 5/10/00, Notice 3/22/00—published 5/31/00, effective 8/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed emergency 6/8/00 after Notice 4/19/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/5/00—published 6/28/00, effective 9/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed emergency 9/12/00 after Notice 7/12/00—published 10/4/00, effective 10/1/00]
[Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
[Filed 11/8/00, Notice 10/4/00—published 11/29/00, effective 1/3/01]
[Filed emergency 12/14/00—published 1/10/01, effective 1/1/01]
[Filed 2/14/01, Notice 1/10/01—published 3/7/01, effective 5/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]◊
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]◊
[Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02]
[Filed emergency 12/12/01—published 1/9/02, effective 1/1/02]
[Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02]
[Filed 2/14/02, Notice 12/26/01—published 3/6/02, effective 5/1/02]
[Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]◊
[Filed emergency 6/13/02—published 7/10/02, effective 7/1/02]
[Filed 10/10/02, Notice 8/21/02—published 10/30/02, effective 1/1/03]
[Filed emergency 12/12/02—published 1/8/03, effective 1/1/03]◊
[Filed emergency 1/9/03 after Notice 11/27/02—published 2/5/03, effective 2/1/03]
[Filed 1/9/03, Notice 11/27/02—published 2/5/03, effective 4/1/03]
[Filed emergency 3/14/03—published 4/2/03, effective 4/1/03]
[Filed without Notice 5/16/03—published 6/11/03, effective 7/16/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed emergency 10/10/03—published 10/29/03, effective 10/10/03]
[Filed emergency 10/10/03—published 10/29/03, effective 11/1/03]
[Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
[Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
[Filed emergency 3/11/04—published 3/31/04, effective 4/1/04]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04]
[Filed emergency 9/23/04 after Notice 7/7/04—published 10/13/04, effective 10/1/04]
[Filed 10/8/04, Notice 7/7/04—published 10/27/04, effective 12/1/04]
[Filed 10/14/04, Notice 8/4/04—published 11/10/04, effective 1/1/05]
[Filed emergency 12/14/04—published 1/5/05, effective 1/1/05]
[Filed emergency 1/13/05 after Notice 12/8/04—published 2/2/05, effective 2/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 6/17/05 after Notice 8/4/04—published 7/6/05, effective 7/1/05]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed emergency 7/15/05 after Notice 5/11/05—published 8/3/05, effective 8/1/05]

[Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed emergency 12/14/05—published 1/4/06, effective 1/1/06]
[Filed emergency 1/12/06 after Notice 11/23/05—published 2/1/06, effective 2/1/06]
[Filed 2/10/06, Notice 1/4/06—published 3/1/06, effective 4/5/06]
[Filed without Notice 4/17/06—published 5/10/06, effective 7/1/06]
[Filed emergency 5/12/06—published 6/7/06, effective 6/1/06]
[Filed emergency 6/16/06 after Notice 4/12/06—published 7/5/06, effective 7/1/06]
[Filed emergency 6/16/06 after Notice 5/10/06—published 7/5/06, effective 7/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]◊
[Filed 7/14/06, Notice 6/7/06—published 8/2/06, effective 9/6/06]
[Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
[Filed 11/8/06, Notice 7/5/06—published 12/6/06, effective 1/10/07]
[Filed 12/13/06, Notice 7/5/06—published 1/3/07, effective 2/7/07]
[Filed 4/11/07, Notice 2/28/07—published 5/9/07, effective 7/1/07]
[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]◊
[Filed emergency 6/15/07—published 7/4/07, effective 7/1/07]◊
[Filed emergency 6/13/07—published 7/4/07, effective 8/1/07]
[Filed emergency 7/12/07 after Notice 5/9/07—published 8/1/07, effective 8/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]◊
[Filed emergency 10/10/07 after Notice 8/29/07—published 11/7/07, effective 11/1/07]
[Filed 12/12/07, Notice 7/4/07—published 1/2/08, effective 2/6/08]◊
[Filed emergency 1/9/08 after Notice 12/5/07—published 1/30/08, effective 2/1/08]
[Filed emergency 2/13/08 after Notice 12/19/07—published 3/12/08, effective 2/15/08]
[Filed emergency 3/12/08—published 4/9/08, effective 3/12/08]
[Filed 4/10/08, Notice 1/30/08—published 5/7/08, effective 7/1/08]
[Filed 4/10/08, Notice 2/27/08—published 5/7/08, effective 7/1/08]
[Filed emergency 6/11/08—published 7/2/08, effective 7/1/08]◊
[Filed 6/11/08, Notice 4/9/08—published 7/2/08, effective 8/6/08]
[Filed 7/9/08, Notice 5/7/08—published 7/30/08, effective 10/1/08]
[Filed emergency 10/14/08 after Notice 7/2/08—published 11/5/08, effective 11/1/08]
[Filed emergency 10/14/08 after Notice 8/27/08—published 11/5/08, effective 11/1/08]
[Filed emergency 11/12/08 after Notice 9/24/08—published 12/3/08, effective 1/1/09]
[Filed 11/12/08, Notice 8/13/08—published 12/3/08, effective 2/1/09]
[Filed ARC 7546B (Notice ARC 7356B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
[Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]
[Filed ARC 7834B (Notice ARC 7630B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
[Filed ARC 7833B (Notice ARC 7629B, IAB 3/11/09), IAB 6/3/09, effective 8/1/09]
[Filed Emergency ARC 7929B, IAB 7/1/09, effective 7/1/09]
[Filed Emergency ARC 7931B, IAB 7/1/09, effective 7/1/09]
[Filed Emergency ARC 7932B, IAB 7/1/09, effective 7/1/09]
[Filed ARC 7935B (Notice ARC 7718B, IAB 4/22/09), IAB 7/1/09, effective 9/1/09]
[Filed ARC 8095B (Notice ARC 7930B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8096B (Notice ARC 7934B, IAB 7/1/09), IAB 9/9/09, effective 10/14/09]
[Filed ARC 8260B (Notice ARC 8056B, IAB 8/26/09), IAB 11/4/09, effective 1/1/10]
[Filed Emergency After Notice ARC 8261B, IAB 11/4/09, effective 10/15/09]
[Filed ARC 8439B (Notice ARC 8083B, IAB 8/26/09), IAB 1/13/10, effective 3/1/10]
[Filed ARC 8443B (Notice ARC 8220B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]
[Filed ARC 8444B (Notice ARC 8221B, IAB 10/7/09), IAB 1/13/10, effective 3/1/10]
[Filed Emergency After Notice ARC 8503B (Notice ARC 8311B, IAB 11/18/09), IAB 2/10/10, effective 1/13/10]

[Filed Emergency After Notice ARC 8500B (Notice ARC 8272B, IAB 11/4/09), IAB 2/10/10, effective 3/1/10]
[Filed Emergency After Notice ARC 8556B (Notice ARC 8407B, IAB 12/16/09), IAB 3/10/10, effective 2/10/10]
[Filed ARC 8642B (Notice ARC 8461B, IAB 1/13/10), IAB 4/7/10, effective 6/1/10]
[Filed Without Notice ARC 8713B, IAB 5/5/10, effective 8/1/10]
[Filed Emergency After Notice ARC 8786B (Notice ARC 8552B, IAB 2/24/10), IAB 6/2/10, effective 6/1/10]
[Filed ARC 8785B (Notice ARC 8619B, IAB 3/24/10), IAB 6/2/10, effective 8/1/10]
[Filed Emergency ARC 8898B, IAB 6/30/10, effective 7/1/10]
[Filed ARC 8897B (Notice ARC 8705B, IAB 4/21/10), IAB 6/30/10, effective 9/1/10]
[Filed ARC 9043B (Notice ARC 8853B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]
[Filed ARC 9044B (Notice ARC 8864B, IAB 6/16/10), IAB 9/8/10, effective 11/1/10]
[Filed ARC 9404B (Notice ARC 9277B, IAB 12/15/10), IAB 3/9/11, effective 5/1/11]
[Filed ARC 9439B (Notice ARC 9309B, IAB 12/29/10), IAB 4/6/11, effective 6/1/11]
[Filed Emergency ARC 9582B, IAB 6/29/11, effective 7/1/11]
[Filed ARC 9581B (Notice ARC 9479B, IAB 4/20/11), IAB 6/29/11, effective 8/3/11]
[Filed Emergency ARC 9647B, IAB 8/10/11, effective 8/1/11]
[Filed Emergency ARC 9696B, IAB 9/7/11, effective 9/1/11]
[Filed ARC 9881B (Notice ARC 9697B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed Emergency After Notice ARC 9956B (Notice ARC 9648B, IAB 8/10/11), IAB 1/11/12, effective 1/1/12]
[Filed Emergency After Notice ARC 9957B (Notice ARC 9804B, IAB 10/19/11), IAB 1/11/12, effective 1/1/12]
[Filed ARC 0149C (Notice ARC 0047C, IAB 3/21/12), IAB 6/13/12, effective 8/1/12]
[Filed Emergency ARC 0192C, IAB 7/11/12, effective 7/1/12]
[Filed ARC 0579C (Notice ARC 0432C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed Emergency After Notice ARC 0822C (Notice ARC 0690C, IAB 4/17/13), IAB 7/10/13, effective 7/1/13]
[Filed Emergency After Notice ARC 0821C (Notice ARC 0691C, IAB 4/17/13), IAB 7/10/13, effective 7/1/13]
[Filed Emergency After Notice ARC 0820C (Notice ARC 0668C, IAB 4/3/13), IAB 7/10/13, effective 8/1/13]
[Filed ARC 0990C (Notice ARC 0746C, IAB 5/15/13), IAB 9/4/13, effective 1/1/14]
[Filed Emergency After Notice ARC 1134C (Notice ARC 0971C, IAB 8/21/13), IAB 10/30/13, effective 10/2/13]
[Filed Emergency ARC 1212C, IAB 12/11/13, effective 1/1/14]
[Filed Emergency ARC 1266C, IAB 1/8/14, effective 1/1/14]
[Filed ARC 1355C (Notice ARC 1265C, IAB 1/8/14), IAB 3/5/14, effective 4/9/14]
[Filed ARC 1356C (Notice ARC 1211C, IAB 12/11/13), IAB 3/5/14, effective 4/9/14]
[Filed ARC 1447C (Notice ARC 1368C, IAB 3/5/14), IAB 4/30/14, effective 7/1/14]
[Filed Emergency After Notice ARC 1484C (Notice ARC 1415C, IAB 4/2/14), IAB 6/11/14, effective 7/1/14]
[Filed Emergency After Notice ARC 1483C (Notice ARC 1416C, IAB 4/2/14), IAB 6/11/14, effective 7/1/14]
[Filed ARC 1482C (Notice ARC 1417C, IAB 4/2/14), IAB 6/11/14, effective 8/1/14]
[Filed Emergency After Notice ARC 2027C (Notice ARC 1952C, IAB 4/1/15), IAB 6/10/15, effective 7/1/15]
[Filed ARC 2029C (Notice ARC 1951C, IAB 4/1/15), IAB 6/10/15, effective 8/1/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 2557C (Notice ARC 2469C, IAB 3/30/16), IAB 6/8/16, effective 8/1/16]

[Filed Emergency After Notice ARC 2605C (Notice ARC 2505C, IAB 4/27/16), IAB 7/6/16, effective 7/1/16]
[Filed ARC 3094C (Notice ARC 3001C, IAB 3/29/17), IAB 6/7/17, effective 8/1/17]
[Filed Emergency After Notice ARC 3182C (Notice ARC 3016C, IAB 4/12/17), IAB 7/5/17, effective 7/1/17]
[Filed Emergency After Notice ARC 3183C (Notice ARC 3017C, IAB 4/12/17), IAB 7/5/17, effective 7/1/17]

◊ Two or more ARCs

[1] 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.

CHAPTER 77
CONDITIONS OF PARTICIPATION FOR PROVIDERS OF MEDICAL AND REMEDIAL CARE

[Prior to 7/1/83, Social Services[770] Ch 77]
[Prior to 2/11/87, Human Services[498]]

441—77.1(249A) Physicians. All physicians (doctors of medicine and osteopathy) licensed to practice in the state of Iowa are eligible to participate in the program. Physicians in other states are also eligible if duly licensed to practice in that state.

441—77.2(249A) Retail pharmacies. Retail pharmacies are eligible to participate if they meet the requirements of this rule.

77.2(1) *Licensure.* Participating retail pharmacies must be licensed in the state of Iowa or duly licensed in another state. Out-of-state retail pharmacies delivering, dispensing, or distributing drugs by any method to an ultimate user physically located in Iowa must be duly licensed by Iowa as a nonresident pharmacy for that purpose.

77.2(2) *Survey participation.* As a condition of participation, retail pharmacies are required to make available drug acquisition cost invoice information, product availability information if known, dispensing cost information, and any other information deemed necessary by the department to assist in monitoring and revising reimbursement rates pursuant to 441—subrule 79.1(8) or for the efficient operation of the pharmacy benefit.

a. A pharmacy shall produce and submit all requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.

b. A pharmacy shall submit information to the department or its designee within the time frame indicated following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy.

c. Any dispensing or acquisition cost information submitted to the department that specifically identifies a pharmacy's individual costs shall be held confidential.

[**ARC 0485C**, IAB 12/12/12, effective 2/1/13]

441—77.3(249A) Hospitals.

77.3(1) *Qualifications.* All hospitals licensed in the state of Iowa or in another state and certified as eligible to participate in Part A of the Medicare program (Title XVIII of the Social Security Act) are eligible to participate in the medical assistance program, subject to the additional requirements of this rule.

77.3(2) *Referral to health home services provider.* As a condition of participation in the medical assistance program, hospitals must establish procedures for referring to health home services providers any members who seek or need treatment in the hospital emergency department and who are eligible for health home services pursuant to 441—subrule 78.53(2).

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

[**ARC 0198C**, IAB 7/11/12, effective 7/1/12]

441—77.4(249A) Dentists. All dentists licensed to practice in the state of Iowa are eligible to participate in the program. Dentists in other states are also eligible if duly licensed to practice in that state.

NOTE: DENTAL LABORATORIES—Payment will not be made to a dental laboratory.

441—77.5(249A) Podiatrists. All podiatrists licensed to practice in the state of Iowa are eligible to participate in the program. Podiatrists in other states are also eligible if duly licensed to practice in that state.

441—77.6(249A) Optometrists. All optometrists licensed to practice in the state of Iowa are eligible to participate in the program. Optometrists in other states are also eligible if duly licensed to practice in that state.

441—77.7(249A) Opticians. All opticians in the state of Iowa are eligible to participate in the program. Opticians in other states are also eligible to participate.

NOTE: Opticians in states having licensing requirements for this professional group must be duly licensed in that state.

441—77.8(249A) Chiropractors. All chiropractors licensed to practice in the state of Iowa are eligible to participate providing they have been determined eligible to participate in Title XVIII of the Social Security Act (Medicare) by the Social Security Administration. Chiropractors in other states are also eligible if duly licensed to practice in that state and determined eligible to participate in Title XVIII of the Social Security Act.

441—77.9(249A) Home health agencies. Home health agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act) and, unless exempted under subrule 77.9(5), have submitted a surety bond as required by subrules 77.9(1) to 77.9(6).

77.9(1) *Definitions.*

"Assets" includes any listing that identifies Medicaid members to whom home health services were furnished by a participating or formerly participating home health agency.

"Rider" means a notice issued by a surety that a change in the bond has occurred or will occur.

"Uncollected overpayment" means a Medicaid overpayment, including accrued interest, for which the home health agency is responsible that has not been recouped by the department within 60 days from the date of notification that an overpayment has been identified.

77.9(2) *Parties to surety bonds.* The surety bond shall name the home health agency as the principal, the Iowa department of human services as the obligee and the surety company (and its heirs, executors, administrators, successors and assignees, jointly and severally) as surety. The bond shall be issued by a company holding a current Certificate of Authority issued by the U.S. Department of the Treasury in accordance with 31 U.S.C. Sections 9304 to 9308 and 31 CFR Part 223 as amended to November 30, 1984, Part 224 as amended to May 29, 1996, and Part 225 as amended to September 12, 1974. The bond shall list the surety's name, street address or post office box number, city, state and ZIP code. The company shall not have been determined by the department to be unauthorized in Iowa due to:

a. Failure to furnish timely confirmation of the issuance of and the validity and accuracy of information appearing on a surety bond that a home health agency presents to the department that shows the surety company as surety on the bond.

b. Failure to timely pay the department in full the amount requested, up to the face amount of the bond, upon presentation by the department to the surety company of a request for payment on a surety bond and of sufficient evidence to establish the surety company's liability on the bond.

c. Other good cause.

The department shall give public notice of a determination that a surety company is unauthorized in Iowa and the effective date of the determination by publication of a notice in the newspaper of widest circulation in each city in Iowa with a population of 50,000 or more. A list of surety companies determined by the department to be unauthorized in Iowa shall be maintained and shall be available for public inspection by contacting the division of medical services of the department. The determination that a surety company is unauthorized in Iowa has effect only in Iowa and is not a debarment, suspension, or exclusion for the purposes of Federal Executive Order No. 12549.

77.9(3) *Surety company obligations.* The bond shall guarantee payment to the department, up to the face amount of the bond, of the full amount of any uncollected overpayment, including accrued interest, based on payments made to the home health agency during the term of the bond. The bond shall provide that payment may be demanded from the surety after available administrative collection methods for collecting from the home health agency have been exhausted.

77.9(4) *Surety bond requirements.* Surety bonds secured by home health agencies participating in Medicaid shall comply with the following requirements:

a. *Effective dates and submission dates.*

(1) Home health agencies participating in the program on June 10, 1998, shall secure either an initial surety bond for the period January 1, 1998, through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(2) Home health agencies seeking to participate in Medicaid and Medicare for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(3) Medicare-certified home health agencies seeking to participate in Medicaid for the first time after June 10, 1998, shall secure an initial surety bond for the period from Medicaid certification through the end of the home health agency's fiscal year or a continuous bond which remains in effect from year to year.

(4) Home health agencies seeking to participate in Medicaid after purchasing the assets of or an ownership interest in a participating or formerly participating agency shall secure an initial surety bond effective as of the date of purchase of the assets or the transfer of the ownership interest for the balance of the current fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

(5) Home health agencies which continue to participate in Medicaid after the period covered by an initial surety bond shall secure a surety bond for each subsequent fiscal year of the home health agency or a continuous bond which remains in effect from year to year.

b. *Amount of bond.* Bonds for any period shall be in the amount of $50,000 or 15 percent of the home health agency's annual Medicaid payments during the most recently completed state fiscal year, whichever is greater. After June 1, 2005, all bonds shall be in the amount of $50,000. At least 90 days before the start of each home health agency's fiscal year, the department shall provide notice of the amount of the surety bond to be purchased and submitted to the Iowa Medicaid enterprise provider services unit.

c. *Other requirements.* Surety bonds shall meet the following additional requirements. The bond shall:

(1) Guarantee that upon written demand by the department to the surety for payment under the bond and the department's furnishing to the surety sufficient evidence to establish the surety's liability under the bond, the surety shall within 60 days pay the department the amount so demanded, up to the stated amount of the bond.

(2) Provide that the surety's liability for uncollected overpayments is based on overpayments determined during the term of the bond.

(3) Provide that the surety's liability to the department is not extinguished by any of the following:

1. Any action by the home health agency or the surety to terminate or limit the scope or term of the bond unless the surety furnishes the department with notice of the action not later than 10 days after the date of notice of the action by the home health agency to the surety and not later than 60 days before the effective date of the action by the surety.

2. The surety's failure to continue to meet the requirements in subrule 77.9(2) or the department's determination that the surety company is an unauthorized surety under subrule 77.9(2).

3. Termination of the home health agency's provider agreement.

4. Any action by the department to suspend, offset, or otherwise recover payments to the home health agency.

5. Any action by the home health agency to cease operations, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the surety.

6. Any fraud, misrepresentation, or negligence by the home health agency in obtaining the surety bond or by the surety (or the surety's agent, if any) in issuing the surety bond; except that any fraud, misrepresentation, or negligence by the home health agency in identifying to the surety (or the surety's agent) the amount of Medicaid payments upon which the amount of the surety bond is determined shall not cause the surety's liability to the department to exceed the amount of the bond.

7. The home health agency's failure to exercise available appeal rights under Medicaid or assign appeal rights to the surety.

(4) Provide that if a home health agency fails to furnish a bond following the expiration date of an annual bond or if a home health agency fails to furnish a rider for a year in which a rider is required or if the home health agency's provider agreement with the department is terminated, the surety shall remain liable under the most recent annual bond or rider to a continuous bond for two years from the date the home health agency was required to submit the annual bond or rider to a continuous bond or for two years from the termination date of the provider agreement.

(5) Provide that actions under the bond may be brought by the department or by an agent designated by the department.

(6) Provide that the surety may appeal department decisions.

77.9(5) *Exemption from surety bond requirements for government-operated home health agencies.* A home health agency operated by a federal, state, local, or tribal government agency is exempt from the bonding requirements of this rule if, during the preceding five years, the home health agency has not had any uncollected overpayments. Government-operated home health agencies having uncollected overpayments during the preceding five years shall not be exempted from the bonding requirements of this rule.

77.9(6) *Government-operated home health agency that loses its exemption.* A government-operated home health agency which has met the criteria for an exemption under subrule 77.9(6) but is later determined by the department not to meet the criteria shall submit a surety bond within 60 days of the date of the department's written notification to the home health agency that it no longer meets the criteria for an exemption, for the period and in the amount required in the notice from the department.

441—77.10(249A) Medical equipment and appliances, prosthetic devices and medical supplies. All dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or in other states are eligible to participate in the program.

441—77.11(249A) Ambulance service. Providers of ambulance service are eligible to participate providing they meet the eligibility requirements for participation in the Medicare program (Title XVIII of the Social Security Act).

441—77.12(249A) Behavioral health intervention. A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies:

1. The Joint Commission accreditation (TJC), or
2. The Healthcare Facilities Accreditation Program (HFAP), or
3. The Commission on Accreditation of Rehabilitation Facilities (CARF), or
4. The Council on Accreditation (COA), or
5. The Accreditation Association for Ambulatory Health Care (AAAHC), or
6. Iowa Administrative Code 441—Chapter 24, "Accreditation of Providers of Services to Persons with Mental Illness, Intellectual Disabilities, or Developmental Disabilities."

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

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.13(249A) Hearing aid dispensers. Hearing aid dispensers are eligible to participate if they are duly licensed by the state of Iowa. Hearing aid dispensers in other states will be eligible to participate if they are duly licensed in that state.

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

441—77.14(249A) Audiologists. Audiologists are eligible to participate in the program when they are duly licensed by the state of Iowa. Audiologists in other states will be eligible to participate when they are duly licensed in that state. In states having no licensure requirement for audiologists, an audiologist shall obtain a license from the state of Iowa.

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

441—77.15(249A) Community mental health centers. Community mental health centers are eligible to participate in the medical assistance program when they comply with the standards for mental health centers in the state of Iowa established by the Iowa mental health authority.

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

441—77.16(249A) Screening centers. Public or private health agencies are eligible to participate as screening centers when they have the staff and facilities needed to perform all of the elements of screening specified in 441—78.18(249A) and meet the department of public health's standards for a child health screening center. The staff members must be employed by or under contract with the screening center. Screening centers shall direct applications to participate to the Iowa Medicaid enterprise provider services unit.

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

441—77.17(249A) Physical therapists. Physical therapists are eligible to participate when they are licensed, in independent practice; and are eligible to participate in the Medicare program.

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

441—77.18(249A) Orthopedic shoe dealers and repair shops. Establishments eligible to participate in the medical assistance program are retail dealers in orthopedic shoes prescribed by physicians or podiatrists and shoe repair shops specializing in orthopedic work as prescribed by physicians or podiatrists.

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

441—77.19(249A) Rehabilitation agencies. Rehabilitation agencies are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

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

441—77.20(249A) Independent laboratories. Independent laboratories are eligible to participate providing they are certified to participate as a laboratory in the Medicare program (Title XVIII of the Social Security Act). An independent laboratory is a laboratory that is independent of attending and consulting physicians' offices, hospitals, and critical access hospitals.

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

441—77.21(249A) Rural health clinics. Rural health clinics are eligible to participate providing they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

441—77.22(249A) Psychologists. All psychologists licensed to practice in the state of Iowa and meeting the current credentialing requirements of the National Register of Health Service Psychologists are eligible to participate in the medical assistance program. Psychologists in other states are eligible to participate when they are duly licensed to practice in that state and meet the current credentialing requirements of the National Register of Health Service Psychologists.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

[**ARC 2165C**, IAB 9/30/15, effective 12/1/15]

441—77.23(249A) Maternal health centers. A maternal health center is eligible to participate in the Medicaid program if the center provides a team of professionals to render prenatal and postpartum care and enhanced perinatal services (see rule 441—78.25(249A)). The prenatal and postpartum care shall be in accordance with the latest edition of the American College of Obstetricians and Gynecologists, Standards for Obstetric Gynecologic Services. The team must have at least a physician, a registered nurse, a licensed dietitian and a person with at least a bachelor's degree in social work, counseling, sociology or psychology. Team members must be employed by or under contract with the center.

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

441—77.24(249A) Ambulatory surgical centers. Ambulatory surgical centers that are not part of hospitals are eligible to participate in the medical assistance program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act). Freestanding ambulatory surgical centers providing only dental services are also eligible to participate in the medical assistance program if the board of dental examiners has issued a current permit pursuant to 650—Chapter 29 for any dentist to administer deep sedation or general anesthesia at the facility.

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

77.25(1) *Definitions.*

"Guardian" means a guardian appointed in probate or juvenile court.

"Major incident" means an occurrence involving a member during service provision that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the member;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

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

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Minor incident" means an occurrence involving a member during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

77.25(2) *Organization and staff.*

a. The prospective provider shall demonstrate the fiscal capacity to initiate and operate the specified programs on an ongoing basis.

b. The provider shall complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employing a person who will provide direct care.

c. A person providing direct care shall be at least 16 years of age.

d. A person providing direct care shall not be an immediate family member of the member.

77.25(3) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS habilitation service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule.

a. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's

supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the member's file.

b. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The member or the member's legal guardian. EXCEPTION: Notification to the member is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The member's case manager.

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

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the member involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other members or nonmembers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the member's file.

c. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of members served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.25(4) *Restraint, restriction, and behavioral intervention.* The provider shall have in place a system for the review, approval, and implementation of ethical, safe, humane, and efficient behavioral intervention procedures. All members receiving home- and community-based habilitation services shall be afforded the protections imposed by these rules when any restraint, restriction, or behavioral intervention is implemented.

a. The system shall include procedures to inform the member and the member's legal guardian of the restraint, restriction, and behavioral intervention policy and procedures at the time of service approval and as changes occur.

b. Restraint, restriction, and behavioral intervention shall be used only for reducing or eliminating maladaptive target behaviors that are identified in the member's restraint, restriction, or behavioral intervention program.

c. Restraint, restriction, and behavioral intervention procedures shall be designed and implemented only for the benefit of the member and shall never be used as punishment, for the convenience of the staff, or as a substitute for a nonaversive program.

d. Restraint, restriction, and behavioral intervention programs shall be time-limited and shall be reviewed at least quarterly.

e. Corporal punishment and verbal or physical abuse are prohibited.

77.25(5) *Case management.* A provider is eligible to participate in the home- and community-based habilitation services program as a provider of case management services if accredited as a case management provider pursuant to 441—Chapter 24.

77.25(6) *Day habilitation.* The following providers may provide day habilitation:

a. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.27(8).

b. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services and began providing services that qualify as day habilitation under 441—subrule 78.27(8) since the agency's last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a," "d," "g,"* or *"h."*

c. An agency that is not accredited by the Commission on Accreditation of Rehabilitation Facilities but has applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.27(8). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that has applied to the Council on Quality and Leadership in Supports for People with Disabilities for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

f. An agency that is accredited under 441—Chapter 24 to provide day treatment or supported community living services.

g. An agency that is certified by the department to provide day habilitation services under the home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A).

h. An agency that is accredited by the International Center for Clubhouse Development.

i. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

77.25(7) *Home-based habilitation.* The following agencies may provide home-based habilitation services:

a. An agency that is certified by the department to provide supported community living services under:

(1) The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

(2) The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. An agency that is accredited under 441—Chapter 24 to provide supported community living services.

c. An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as a community housing or supported living service provider.

d. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

e. An agency that is accredited by the Council on Accreditation of Services for Families and Children.

f. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

77.25(8) *Prevocational habilitation.*

a. The following providers may provide prevocational services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) An agency that is accredited by the Council on Quality and Leadership.

(3) An agency that is accredited by the International Center for Clubhouse Development.

(4) An agency that is certified by the department to provide prevocational services under:

1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent degree. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment service training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

77.25(9) *Supported employment habilitation.*

a. The following agencies may provide supported employment services:

(1) An agency that is certified by the department to provide supported employment services under:

1. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

2. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(3) An agency that is accredited by the Council on Accreditation.

(4) An agency that is accredited by the Joint Commission.

(5) An agency that is accredited by the Council on Quality and Leadership.

(6) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.25(10) *Provider enrollment.* Rescinded IAB 1/6/16, effective 1/1/16.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—77.26(249A) Behavioral health services. The following persons are eligible to participate in the Medicaid program as providers of behavioral health services.

77.26(1) *Licensed marital and family therapists (LMFT).* Any person licensed by the board of behavioral science as a marital and family therapist pursuant to 645—Chapter 31 is eligible to participate. A marital and family therapist in another state is eligible to participate when duly licensed to practice in that state.

77.26(2) *Licensed independent social workers (LISW).* Any person licensed by the board of social work as an independent social worker pursuant to 645—Chapter 280 is eligible to participate. An independent social worker in another state is eligible to participate when duly licensed to practice in that state.

77.26(3) *Licensed master social workers (LMSW).*

a. A person licensed by the board of social work as a master social worker pursuant to 645—Chapter 280 is eligible to participate when the person:

(1) Holds a master's or doctoral degree as approved by the board of social work; and

(2) Provides treatment under the supervision of an independent social worker licensed pursuant to 645—Chapter 280.

b. A master social worker in another state is eligible to participate when the person:

(1) Is duly licensed to practice in that state; and

(2) Provides treatment under the supervision of an independent social worker duly licensed in that state.

77.26(4) *Licensed mental health counselors (LMC).* Any person licensed by the board of behavioral science as a mental health counselor pursuant to Iowa Code chapter 154D and 645—Chapter 31 is eligible to participate. A mental health counselor in another state is eligible to participate when duly licensed to practice in that state.

77.26(5) *Certified alcohol and drug counselors.* Any person certified by the nongovernmental Iowa board of substance abuse certification as an alcohol and drug counselor is eligible to participate.

This rule is intended to implement Iowa Code chapter 249A as amended by 2011 Iowa Acts, Senate File 233.

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—77.27(249A) Birth centers. Birth centers are eligible to participate in the Medicaid program if they are licensed or receive reimbursement from at least two third-party payors.

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

441—77.28(249A) Area education agencies. An area education agency is eligible to participate in the Medicaid program when it has a plan for providing comprehensive special education programs and services approved by the Iowa department of education. Covered services shall be provided by personnel who are licensed, endorsed, or registered as provided in this rule and shall be within the scope of the applicable license, endorsement, or registration.

77.28(1) Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

77.28(2) Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

77.28(3) Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

77.28(4) Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

a. Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to 282—subrule 27.3(3);

b. Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

c. Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

d. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

e. Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

77.28(5) Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

77.28(6) Personnel providing vision services shall be:

a. Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

b. Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

c. Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

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

[**ARC 1807C**, IAB 1/7/15, effective 3/1/15]

441—77.29(249A) Case management provider organizations. Case management provider organizations are eligible to participate in the Medicaid program provided that they meet the standards for the populations being served. Providers shall meet the following standards:

77.29(1) *Standards in 441—Chapter 24.* Providers shall be accredited as case management providers pursuant to 441—Chapter 24 as a condition of providing case management services to persons with an intellectual disability, developmental disabilities or chronic mental illness.

77.29(2) *Standards in 441—Chapter 186.* Rescinded IAB 10/12/05, effective 10/1/05.

[**ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—77.30(249A) HCBS health and disability waiver service providers. HCBS health and disability waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the member served or the parent or stepparent of a member aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A provider hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following

providers shall be eligible to participate in the Medicaid HCBS health and disability waiver program if they meet the standards in subrule 77.30(18) and also meet the standards set forth below for the service to be provided:

77.30(1) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.30(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.30(3) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.30(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.30(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(3) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.30(3).

(8) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.30(6) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.30(7) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.30(8) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.30(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the elderly waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.30(10) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies that meet the conditions of participation set forth in subrule 77.33(2).

77.30(11) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.30(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians approved by an area agency on aging.

77.30(13) *Financial management service.* Members who elect the consumer choices option shall work with a financial institution that meets the following qualifications.

a. The financial institution shall either:

(1) Be cooperative, nonprofit, member-owned and member-controlled, and federally insured through and chartered by either the National Credit Union Administration (NCUA) or the credit union division of the Iowa department of commerce; or

(2) Be chartered by the Office of the Comptroller of the Currency, a bureau of the U.S. Department of the Treasury, and insured by the Federal Deposit Insurance Corporation (FDIC).

b. The financial institution shall complete a financial management readiness review and certification conducted by the department or its designee.

c. The financial institution shall obtain an Internal Revenue Service federal employee identification number dedicated to the financial management service.

d. The financial institution shall enroll as a Medicaid provider.

77.30(14) *Independent support brokerage.* Members who elect the consumer choices option shall work with an independent support broker who meets the following qualifications.

a. The broker must be at least 18 years of age.

b. The broker shall not be the member's guardian, conservator, attorney in fact under a durable power of attorney for health care, power of attorney for financial matters, trustee, or representative payee.

c. The broker shall not provide any other paid service to the member.

d. The broker shall not work for an individual or entity that is providing services to the member.

e. The broker must consent to a criminal background check and child and dependent adult abuse checks. The results shall be provided to the member.

f. The broker must complete independent support brokerage training approved by the department.

77.30(15) *Self-directed personal care.* Members who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the following requirements.

a. A business providing self-directed personal care services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed personal care services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed personal care services shall:

(1) Be at least 16 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed personal care services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(16) *Individual-directed goods and services.* Members who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the following requirements.

a. A business providing individual-directed goods and services shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing individual-directed goods and services shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing individual-directed goods and services shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of individual-directed goods and services shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(17) *Self-directed community supports and employment.* Members who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the following requirements.

a. A business providing community supports and employment shall:

(1) Have all the necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations; and

(2) Have current liability and workers' compensation coverage.

b. An individual providing self-directed community supports and employment shall have all the necessary licenses required by federal, state, and local laws, including a valid driver's license if providing transportation.

c. All personnel providing self-directed community supports and employment shall:

(1) Be at least 18 years of age.

(2) Be able to communicate successfully with the member.

(3) Not be the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

(4) Not be the recipient of respite services paid through the consumer choices option on behalf of a member who receives the consumer choices option.

(5) Not be the parent or stepparent of a minor child member or the spouse of a member.

d. The provider of self-directed community supports and employment shall:

(1) Prepare timecards or invoices approved by the department that identify what services were provided and the time when services were provided.

(2) Submit invoices and timesheets to the financial management service no later than 30 calendar days from the date when the last service in the billing period was provided. Payment shall not be made if invoices and timesheets are received after this 30-day period.

77.30(18) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS health and disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, home-delivered meals, or personal emergency response.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;

2. Results in the death of any person;

3. Requires emergency mental health treatment for the consumer;

4. Requires the intervention of law enforcement;

5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

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

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

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.31(249A) Occupational therapists. Occupational therapists are eligible to participate if they are licensed and in private practice independent of the administrative and professional control of an employer such as a physician, institution, or rehabilitation agency. Licensed occupational therapists in an independent group practice are eligible to enroll.

77.31(1) Occupational therapists in other states are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.31(2) Occupational therapists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

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

441—77.32(249A) Hospice providers. Hospice providers are eligible to participate in the Medicaid program providing they are certified to participate in the Medicare program.

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

441—77.33(249A) HCBS elderly waiver service providers. HCBS elderly waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS elderly waiver program if they meet the standards in subrule 77.33(22) and also meet the standards set forth below for the service to be provided:

77.33(1) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.33(2) *Emergency response system providers.* Emergency response system providers must meet the following standards:

a. The agency shall provide an electronic component to transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The central monitoring station must operate receiving equipment and be fully staffed by trained attendants, 24 hours a day, seven days per week. The attendants must process emergency calls and ensure the timely notification of appropriate emergency resources to be dispatched to the person in need.

b. The agency, parent agency, institution or corporation shall have the necessary legal authority to operate in conformity with federal, state and local laws and regulations.

c. There shall be a governing authority which is responsible for establishing policy and ensuring effective control of services and finances. The governing authority shall employ or contract for an agency administrator to whom authority and responsibility for overall agency administration are delegated.

d. The agency or institution shall be in compliance with all legislation relating to prohibition of discriminatory practices.

e. There shall be written policies and procedures established to explain how the service operates, agency responsibilities, client responsibilities and cost information.

77.33(3) *Home health aide providers.* Home health aide providers shall be agencies certified to participate in the Medicare program as home health agencies.

77.33(4) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.33(5) *Nursing care.* Nursing care providers shall be agencies which are certified to participate in the Medicare program as home health agencies.

77.33(6) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Camps certified by the American Camping Association.

(4) Respite providers certified under the home- and community-based services intellectual disability waiver.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.33(4).

(6) Adult day care providers that meet the conditions set forth in subrule 77.33(1).

(7) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of the spouse, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the spouse, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the spouse, guardian, or primary caregiver of any injuries or illnesses that occur during respite provision. A spouse's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the spouse, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the spouse, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the spouse, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.33(7) *Chore providers.* The following providers may provide chore services:

a. Home health agencies certified under Medicare.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Providers that were enrolled as chore providers as of June 30, 2010, based on a subcontract with or letter of approval from an area agency on aging.

f. Community businesses that are engaged in the provision of chore services and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(8) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Restaurants licensed and inspected under Iowa Code chapter 137F.

e. Hospitals enrolled as Medicaid providers.

f. Home health aide providers meeting the standards set forth in subrule 77.33(3).

g. Medical equipment and supply dealers certified to participate in the Medicaid program.

h. Home care providers meeting the standards set forth in subrule 77.33(4).

77.33(9) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Area agencies on aging as designated in 17—4.4(231).

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Providers eligible to participate as home and vehicle modification providers under the health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

d. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and that submit verification of current liability and workers' compensation coverage.

77.33(10) *Mental health outreach providers.* Community mental health centers or other mental health providers accredited by the mental health and developmental disabilities commission pursuant to 441—Chapter 24 may provide mental health outreach services.

77.33(11) *Transportation providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231). Transportation providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services may also provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Rescinded IAB 3/10/99, effective 5/1/99.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.33(12) *Nutritional counseling.* The following providers may provide nutritional counseling by a dietitian licensed under 645—Chapter 81:

a. Hospitals enrolled as Medicaid providers.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

d. Home health agencies certified by Medicare.

e. Independent licensed dietitians.

77.33(13) *Assistive device providers.* The following providers may provide assistive devices:

a. Medicaid-enrolled medical equipment and supply dealers.

b. Area agencies on aging as designated according to department on aging rules 17—4.4(231) and 17—4.9(231).

c. Providers that were enrolled as assistive device providers as of June 30, 2010, based on a contract with or letter of approval from an area agency on aging.

d. Community businesses that are engaged in the provision of assistive devices and that:

(1) Have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations, and

(2) Submit verification of current liability and workers' compensation coverage.

77.33(14) *Senior companions.* Senior companion programs designated by the Corporation for National and Community Service may provide senior companion service.

77.33(15) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.33(16) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.33(17) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.33(18) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.33(19) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.33(20) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.33(21) *Case management providers.* A case management provider organization is eligible to participate in the Medicaid HCBS elderly waiver program if the organization meets the following standards:

a. The case management provider shall be an agency or individual that:

(1) Is accredited by the mental health, mental retardation, developmental disabilities, and brain injury commission as meeting the standards for case management services in 441—Chapter 24; or

(2) Is accredited through the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to provide case management; or

(3) Is accredited through the Council on Accreditation of Rehabilitation Facilities (CARF) to provide case management; or

(4) Is accredited through the Council on Quality and Leadership in Supports for People with Disabilities (CQL) to provide case management; or

(5) Is approved by the department on aging as meeting the standards for case management services in 17—Chapter 21; or

(6) Is authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services and that:

1. Meets the qualifications for case managers in 641—subrule 80.6(1); and
2. Provides a current IDPH local public health services contract number.

b. A case management provider shall not provide direct services to the consumer. The department and the Centers for Medicare and Medicaid Services deem the provision of direct services to case management consumers to be a conflict of interest. A person cannot be the first-line supervisor of both case managers and direct service staff who are providing services to elderly waiver consumers. The provider must have written conflict of interest policies that include, but are not limited to:

(1) Specific procedures to identify conflicts of interest.

(2) Procedures to eliminate any conflict of interest that is identified.

(3) Procedures for handling complaints of conflict of interest, including written documentation.

c. If the case management provider organization subcontracts case management services to another entity:

(1) That entity must also meet the provider qualifications in this subrule; and

(2) The contractor is responsible for verification of compliance.

77.33(22) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS elderly waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of assistive devices, chore service, goods and services purchased under the consumer choices option, home and vehicle modification, home-delivered meals, personal emergency response, or transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's

supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

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

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.33(23) *Assisted living on-call service.* Assisted living on-call service providers shall be assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.34(249A) HCBS AIDS/HIV waiver service providers. HCBS AIDS/HIV waiver services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage,

self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider. The following providers shall be eligible to participate in the Medicaid HCBS AIDS/HIV waiver program if they meet the standards in subrule 77.34(14) and also meet the standards set forth below for the service to be provided:

77.34(1) *Counseling providers.* Counseling providers shall be:

a. Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

b. Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

c. Agencies which are accredited under the mental health service provider standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

77.34(2) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program.

77.34(3) *Homemaker providers.* Homemaker providers shall be agencies that are:

a. Certified as a home health agency under Medicare, or

b. Authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

77.34(4) *Nursing care providers.* Nursing care providers shall be agencies which are certified to meet the standards under the Medicare program for home health agencies.

77.34(5) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Home health agencies that are certified to participate in the Medicare program.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, or hospitals enrolled as providers in the Iowa Medicaid program.

(3) Respite providers certified under the home- and community-based services intellectual disability or brain injury waiver.

(4) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(5) Camps certified by the American Camping Association.

(6) Home care agencies that meet the conditions of participation set forth in subrule 77.34(3).

(7) Adult day care providers that meet the conditions of participation set forth in subrule 77.34(7).

(8) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian, or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.34(6) *Home-delivered meals.* The following providers may provide home-delivered meals:

a. Home health aide providers meeting the standards set forth in subrule 77.34(2).

b. Home care providers meeting the standards set forth in subrule 77.34(3).

c. Hospitals enrolled as Medicaid providers.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Restaurants licensed and inspected under Iowa Code chapter 137F.

f. Community action agencies as designated in Iowa Code section 216A.93. Home-delivered meals providers subcontracting with community action agencies or with letters of approval from the community action agencies stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

g. Area agencies on aging as designated in 17—4.4(231). Home-delivered meals providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating the organization is qualified to provide home-delivered meals services may also provide home-delivered meals services.

h. Medical equipment and supply dealers certified to participate in the Medicaid program.

77.34(7) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.34(8) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.34(9) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.34(10) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.34(11) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.34(12) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.34(13) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

77.34(14) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS AIDS/HIV waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or to home-delivered meals.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

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

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.35(249A) Federally qualified health centers. Federally qualified health centers are eligible to participate in the Medicaid program when the Centers for Medicare and Medicaid Services has notified the Medicaid program of their eligibility as allowed by Section 6404(b) of Public Law 101-239.

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

441—77.36(249A) Advanced registered nurse practitioners. Advanced registered nurse practitioners are eligible to participate in the Medicaid program if they are duly licensed and registered by the state of Iowa as advanced registered nurse practitioners certified pursuant to board of nursing rules 655—Chapter 7.

77.36(1) Advanced registered nurse practitioners in another state shall be eligible to participate if they are duly licensed and registered in that state as advanced registered nurse practitioners with certification in a practice area consistent with board of nursing rules 655—Chapter 7.

77.36(2) Advanced registered nurse practitioners who have been certified eligible to participate in Medicare shall be considered as having met these guidelines.

77.36(3) Licensed nurse anesthetists who have graduated from a nurse anesthesia program meeting the standards set forth by a national association of nurse anesthetists within the past 18 months and who are awaiting initial certification by a national association of nurse anesthetists approved by the board of nursing shall be considered as having met these guidelines.

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

441—77.37(249A) Home- and community-based services intellectual disability waiver service providers. Providers shall be eligible to participate in the Medicaid HCBS intellectual disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service.

The standards in subrule 77.37(1) apply only to providers of supported employment, respite providers certified according to subparagraph 77.37(15)*"a"*(8), and providers of supported community living services that are not residential-based. The standards and certification processes in subrules 77.37(2) through 77.37(7) and 77.37(9) through 77.37(12) apply only to supported employment providers and non-residential-based supported community living providers.

The requirements in subrule 77.37(13) apply to all providers. EXCEPTION: A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the review requirements in subrule 77.37(13). Also, services must be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

77.37(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for home- and community-based services intellectual disability providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumer's needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.37(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.37(3) *Contracts with consumers.* The provider shall have written procedures which provide for the establishment of an agreement between the consumer and the provider.

a. The agreement shall define the responsibilities of the provider and the consumer, the rights of the consumer, the services to be provided to the consumer by the provider, all room and board and copay fees to be charged to the consumer and the sources of payment.

b. Contracts shall be reviewed at least annually.

77.37(4) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.37(5) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

If the provider has a physician on staff or under contract, the physician shall review and document the provider's prescribed medication regime at least annually in accordance with current medical practice.

77.37(6) *Research.* If the provider conducts research involving human subjects, the provider shall have written policies and procedures for research which ensure the rights of consumers and staff.

77.37(7) *Abuse reporting requirements.* The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

77.37(8) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS intellectual disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff consumer's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

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

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

(3) The following information shall be reported:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. *Tracking and analysis.* The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.37(9) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral. Service coordination means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

b. The provider shall ensure the rights of persons applying for services.

77.37(10) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.37(11) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved. Providers shall be responsible for notifying the appropriate county and the appropriate central point of coordination of the determination.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

(3) The prospective provider's coordination of service design, development, and application with the applicable region and other interested parties.

(4) The prospective provider's written agreement to work cooperatively with the state, counties and regions to be served by the provider.

c. Providers applying for initial certification shall be offered technical assistance.

77.37(12) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.37(1) and 77.37(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) Three-year certification with excellence. An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) Three-year certification with follow-up monitoring. An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together are 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) One-year certification. An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up

monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) Probational certification. A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended, and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall be notified immediately to discontinue funding for that provider's service. If a member is in immediate jeopardy, the case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from a home- and community-based services intellectual disability waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.37(13) *Review of providers.* Reviews of compliance with standards as indicated in this chapter shall be conducted by designated members of the HCBS staff.

a. This review may include on-site case record audits; review of administrative procedures, clinical practices, personnel records, performance improvement systems and documentation; and interviews with staff, consumers, the board of directors, or others deemed appropriate, consistent with the confidentiality safeguards of state and federal laws.

b. A review visit shall be scheduled with the provider with additional reviews conducted at the discretion of the department.

c. The on-site review team will consist of designated members of the HCBS staff.

d. Following a certification review, the certification review team leader shall submit a copy of the department's written report of findings to the provider within 30 working days after completion of the certification review.

e. The provider shall develop a plan of corrective action, if applicable, identifying completion time frames for each review recommendation.

f. Providers required to make corrective actions and improvements shall submit the corrective action and improvement plan to the Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, within 30 working days after the receipt of a report issued as a result of the review team's visit. The corrective actions may include: specific problem areas cited, corrective actions to be implemented by the provider, dates by which each corrective measure will be completed, and quality assurance and improvement activities to measure and ensure continued compliance.

g. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to 77.37(13)*"e"* and 77.37(13)*"f."*

h. The department may conduct a site visit to verify all or part of the information submitted.

77.37(14) *Supported community living providers.*

a. The department will contract only with public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113.

d. All supported community living providers shall meet the following requirements:

(1) The provider shall demonstrate how the provider will meet the outcomes and processes in rule 441—77.37(249A) for each of the consumers being served. The provider shall supply timelines showing how the provider will come into compliance with rules 441—77.37(249A), 441—78.41(249A), and 441—83.60(249A) to 441—83.70(249A) and 441—subrule 79.1(15) within one year of certification. These timelines shall include:

1. Implementation of necessary staff training and consumer input.

2. Implementation of provider system changes to allow for flexibility in staff duties, services based on what each individual needs, and removal of housing as part of the service.

(2) The provider shall demonstrate that systems are in place to measure outcomes and processes for individual consumers before certification can be given.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;

2. The quantity of affordable rental housing in the county is insufficient to meet the need; or

3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.37(15) *Respite care providers.*

a. The following agencies may provide respite services:

(1) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(2) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(3) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(4) Home health agencies that are certified to participate in the Medicare program.

(5) Camps certified by the American Camping Association.

(6) Adult day care providers that meet the conditions of participation set forth in subrule 77.37(25).

(7) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(8) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of 77.37(1) and 77.37(3) through 77.37(9).

(9) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.

2. An emergency medical care release.

3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.

4. The consumer's medical issues, including allergies.

5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.

2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.

3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.

4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver

and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.37(16) *Supported employment providers.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider, or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation for similar services.

(3) An agency that is accredited by the Joint Commission for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.37(17) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers certified to participate as supported community living service providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the brain injury waiver.

c. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.37(18) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2) to maintain certification.

77.37(19) *Nursing providers.* Nursing providers shall be agencies that are certified to participate in the Medicare program as home health agencies.

77.37(20) *Home health aide providers.* Home health aide providers shall be agencies which are certified to participate in the Medicare program as home health agencies and which have an HCBS agreement with the department.

77.37(21) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.37(22) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.37(23) *Residential-based supported community living service providers.*

a. The department shall contract only with public or private agencies to provide residential-based supported community living services.

b. Subject to the requirements of this rule, the following agencies may provide residential-based supported community living services:

(1) Agencies licensed as group living foster care facilities under 441—Chapter 114.

(2) Agencies licensed as residential facilities for mentally retarded children under 441—Chapter 116.

(3) Other agencies providing residential-based supported community living services that meet the following conditions:

1. The agency must provide orientation training on the agency's purpose, policies, and procedures within one month of hire or contracting for all employed and contracted treatment staff and must provide 24 hours of training during the first year of employment or contracting. The agency must also provide at least 12 hours of training per year after the first year of employment for all employed and contracted treatment staff. Annual training shall include, at a minimum, training on children's mental retardation and developmental disabilities services and children's mental health issues.Identification and reporting of child abuse shall be covered in training at least every five years, in accordance with Iowa Code section 232.69.

2. The agency must have standards for the rights and dignity of children that are age-appropriate. These standards shall include the following:

- Children, their families, and their legal representatives decide what personal information is shared and with whom.
- Children are a part of family and community life and perform varied social roles.
- Children have family connections, a social network, and varied relationships.
- Children develop and accomplish personal goals.
- Children are valued.
- Children live in positive environments.
- Children exercise their rights and responsibilities.
- Children make informed choices about how they spend their free time.
- Children choose their daily routine.

3. The agency must use methods of self-evaluation by which:

- Past performance is reviewed.
- Current functioning is evaluated.
- Plans are made for the future based on the review and evaluation.

4. The agency must have a governing body that receives and uses input from a wide range of local community interests and consumer representatives and provides oversight that ensures the provision of high-quality supports and services to children.

5. Children, their parents, and their legal representatives must have the right to appeal the service provider's application of policies or procedures or any staff person's action that affects the consumer. The service provider shall distribute the policies for consumer appeals and procedures to children, their parents, and their legal representatives.

c. As a condition of participation, all providers of residential-based supported community living services must have the following on file:

(1) Current accreditations, evaluations, inspections, and reviews by applicable regulatory and licensing agencies and associations.

(2) Documentation of the fiscal capacity of the provider to initiate and operate the specified programs on an ongoing basis.

(3) The provider's written agreement to work cooperatively with the department.

d. As a condition of participation, all providers of residential-based supported community living services must develop, review, and revise service plans for each child, as follows:

(1) The service plan shall be developed in collaboration with the social worker or case manager, child, family, and, if applicable, the foster parents, unless a treatment rationale for the lack of involvement of one of these parties is documented in the plan. The service provider shall document the dates and content of the collaboration on the service plan. The service provider shall provide a copy of the service plan to the family and the case manager, unless otherwise ordered by a court of competent jurisdiction.

(2) Initial service plans shall be developed after services have been authorized and within 30 calendar days of initiating services.

(3) The service plan shall identify the following:

1. Strengths and needs of the child.
2. Goals to be achieved to meet the needs of the child.

3. Objectives for each goal that are specific, measurable, and time-limited and include indicators of progress toward each goal.

4. Specific service activities to be provided to achieve the objectives.

5. The persons responsible for providing the services. When daily living and social skills development is provided in a group care setting, designation may be by job title.

6. Date of service initiation and date of individual service plan development.

7. Service goals describing how the child will be reunited with the child's family and community.

(4) Individuals qualified to provide all services identified in the service plan shall review the services identified in the service plan to ensure that the services are necessary, appropriate, and consistent with the identified needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

(5) The service worker or case manager shall review all service plans to determine progress toward goals and objectives 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services.

At a minimum, the provider shall submit written reports to the service worker or case manager at six-month intervals and when changes to the service plan are needed.

(6) The individual service plan shall be revised when any of the following occur:

1. Service goals or objectives have been achieved.

2. Progress toward goals and objectives is not being made.

3. Changes have occurred in the identified service needs of the child, as listed on the Supports Intensity Scale® (SIS) assessment.

4. The service plan is not consistent with the identified service needs of the child, as listed in the service plan.

(7) The service plan shall be signed and dated by qualified staff of each reviewing provider after each review and revision.

(8) Any revisions of the service plan shall be made in collaboration with the child, family, case manager, and, if applicable, the foster parents and shall reflect the needs of the child. The service provider shall provide a copy of the revised service plan to the family and case manager, unless otherwise ordered by a court of competent jurisdiction.

e. The residential-based supportive community living service provider shall also furnish residential-based living units for all recipients of the residential-based supported community living services. Except as provided herein, living units provided may be of no more than four beds. Service providers who receive approval from the bureau of long-term care may provide living units of up to eight beds. The bureau shall approve five- to eight-bed living units only if all of the following conditions are met:

(1) Rescinded IAB 8/7/02, effective 10/1/02.

(2) There is a need for the service to be provided in a five- to eight-person living unit instead of a smaller living unit, considering the location of the programs in an area.

(3) The provider supplies the bureau of long-term care with a written plan acceptable to the department that addresses how the provider will reduce its living units to four-bed units within a two-year period of time. This written plan shall include the following:

1. How the transition will occur.

2. What physical change will need to take place in the living units.

3. How children and their families will be involved in the transitioning process.

4. How this transition will affect children's social and educational environment.

f. Certification process and review of service providers.

(1) The certification process for providers of residential-based supported community living services shall be pursuant to subrule 77.37(10).

(2) The initial certification of residential-based supported community living services shall be pursuant to subrule 77.37(11).

(3) Period and conditions of certification.

1. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days, effective on the date identified on the certificate of approval, based on documentation provided.

2. Recertification. After the initial certification, recertification shall be based on an on-site review and shall be contingent upon demonstration of compliance with certification requirements.

An exit conference shall be held with the provider to share preliminary findings of the recertification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Recertification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate one year from the month of issuance.

Corrective actions may be required in connection with recertification and may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

3. Probational certification. Probational certification for 270 calendar days may be issued to a provider who cannot demonstrate compliance with all certification requirements on recertification review to give the provider time to establish and implement corrective actions and improvement activities.

During the probational certification period, the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports, or technical assistance.

Probational certification shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider must demonstrate compliance with all certification requirements at the time of the follow-up review in order to maintain certification.

4. Immediate jeopardy. If, during the course of any review, a review team member encounters a situation that places a member in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, the provider shall not be certified. The department shall immediately discontinue funding for that provider's service. If this action is appealed and the member or legal guardian wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk. The case manager or department service worker shall notify the county or region in the event the county or region is funding a service that may assist the member in the situation.

5. Abuse reporting. As a mandatory reporter, each review team member shall follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

6. Extensions. The department shall establish the length of extensions on a case-by-case basis. The department may grant an extension to the period of certification for the following reasons:

- A delay in the department's approval decision exists which is beyond the control of the provider or department.
- A request for an extension is received from a provider to permit the provider to prepare and obtain department approval of corrective actions.

7. Revocation. The department may revoke the provider's approval at any time for any of the following reasons:

- The findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.37(13)*"e"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider has failed to provide information requested pursuant to paragraph 77.37(13)*"f"* and numbered paragraph 77.37(23)*"f"*(3)"4."
- The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.37(13)*"h"* and subparagraph 77.37(23)*"f"*(3).
- There are instances of noncompliance with the standards that were not identified from information submitted on the application.

8. Notice of intent to withdraw. An approved provider shall immediately notify the department, applicable county, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw as a provider of residential-based supported community living services.

9. Technical assistance. Following certification, any provider may request technical assistance from the department regarding compliance with program requirements. The department may require that technical assistance be provided to a provider to assist in the implementation of any corrective action plan.

10. Appeals. The provider can appeal any adverse action under 441—Chapter 7.

(4) Providers of residential-based supported community living services shall be subject to reviews of compliance with program requirements pursuant to subrule 77.37(13).

77.37(24) *Transportation service providers.* The following providers may provide transportation:

a. Accredited providers of home- and community-based services.

b. Regional transit agencies as recognized by the Iowa department of transportation.

c. Transportation providers that contract with county governments.

d. Community action agencies as designated in Iowa Code section 216A.93.

e. Nursing facilities licensed under Iowa Code chapter 135C.

f. Area agencies on aging as designated in rule 17—4.4(231), subcontractors of area agencies on aging, or organizations with letters of approval from the area agencies on aging stating that the organization is qualified to provide transportation services.

g. Transportation providers contracting with the nonemergency medical transportation contractor.

77.37(25) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.37(26) *Prevocational service providers.*

a. Providers of prevocational services must be accredited by one of the following:

(1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) The Council on Quality and Leadership accreditation in supports for people with disabilities.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Prevocational direct support staff shall complete 4 hours of continuing education in employment services annually.

77.37(27) *Day habilitation providers.* Day habilitation services may be provided by:

a. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide services that qualify as day habilitation under 441—subrule 78.41(14).

b. Agencies accredited by the Commission on Accreditation of Rehabilitation Facilities to provide other services that began providing services that qualify as day habilitation under 441—subrule 78.41(14)

since their last accreditation survey. The agency may provide day habilitation services until the current accreditation expires. When the current accreditation expires, the agency must qualify under paragraph *"a"* or *"d."*

c. Agencies not accredited by the Commission on Accreditation of Rehabilitation Facilities that have applied to the Commission within the last 12 months for accreditation to provide services that qualify as day habilitation under 441—subrule 78.41(14). An agency that has not received accreditation within 12 months after application to the Commission is no longer a qualified provider.

d. Agencies accredited by the Council on Quality and Leadership.

e. Agencies that have applied to the Council on Quality and Leadership for accreditation within the last 12 months. An agency that has not received accreditation within 12 months after application to the Council is no longer a qualified provider.

77.37(28) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.37(29) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.37(30) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.37(31) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.37(32) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16]

441—77.38(249A) Assertive community treatment. Services in the assertive community treatment (ACT) program shall be rendered by a multidisciplinary team composed of practitioners from the disciplines described in this rule. The team shall be under the clinical supervision of a psychiatrist. The program shall designate an individual team member who shall be responsible for administration of the program, including authority to sign documents and receive payment on behalf of the program.

77.38(1) *Minimum composition.* At a minimum, the team shall consist of a nurse, a mental health service provider, and a substance abuse treatment professional.

77.38(2) *Psychiatrists.* A psychiatrist on the team shall be a physician (MD or DO) who:

a. Is licensed under 653—Chapter 9,

b. Is certified as a psychiatrist by the American Board of Medical Specialties' Board of Psychiatry and Neurology or by the American Osteopathic Board of Neurology and Psychiatry, and

c. Has experience treating serious and persistent mental illness.

77.38(3) *Registered nurses.* A nurse on the team shall:

a. Be licensed as a registered nurse under 655—Chapter 3, and

b. Have experience treating persons with serious and persistent mental illness.

77.38(4) *Mental health service providers.* A mental health service provider on the team shall be:

a. A mental health counselor or marital and family therapist who:

(1) Is licensed under 645—Chapter 31, and

(2) Has experience treating persons with serious and persistent mental illness; or

b. A social worker who:

(1) Is licensed as a master or independent social worker under 645—Chapter 280, and

(2) Has experience treating persons with serious and persistent mental illness.

77.38(5) *Psychologists.* A psychologist on the team shall:

a. Be licensed under 645—Chapter 240, and

b. Have experience treating persons with serious and persistent mental illness.

77.38(6) *Substance abuse treatment professionals.* A substance abuse treatment professional on the team shall:

a. Be an appropriately credentialed counselor pursuant to 641—paragraph 155.21(8)*"i,"* and

b. Have at least three years of experience treating substance abuse.

77.38(7) *Peer specialists.* A peer specialist on the team shall be a person with serious and persistent mental illness who has met all requirements of a nationally standardized peer support training program, including at least 30 hours of training and satisfactory completion of an examination.

77.38(8) *Community support specialists.* A community support specialist on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services), and

b. Has experience supporting persons with serious and persistent mental illness.

77.38(9) *Case managers.* A case manager on the team shall be a person who:

a. Has a bachelor's degree (BA or BS) in a human services field (sociology, social work, counseling, psychology, or human services),

b. Has experience managing care for persons with serious and persistent mental illness, and

c. Meets the qualifications of "qualified case managers and supervisors" in rule 441—24.1(225C).

77.38(10) *Advanced registered nurse practitioners.* An advanced registered nurse practitioner on the team shall:

a. Be licensed under 655—Chapter 7,

b. Have a mental health certification, and

c. Have experience treating serious and persistent mental illness.

77.38(11) *Physician assistants.* A physician assistant on the team shall:

a. Be licensed under 645—Chapter 326,

b. Have experience treating persons with serious and persistent mental illness, and

c. Practice under the supervision of a psychiatrist.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11]

441—77.39(249A) HCBS brain injury waiver service providers. Providers shall be eligible to participate in the Medicaid brain injury waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Beginning January 1, 2015, providers initially enrolling to deliver BI waiver services and each of their staff members involved in direct consumer service must have completed the department's brain injury training modules one and two within 60 days from the beginning date of service provision, with the exception of staff members who are certified through the Academy of Certified Brain Injury Specialists (ACBIS) as a certified brain injury specialist (CBIS) or certified brain injury specialist trainer (CBIST), providers of home and vehicle modification, specialized medical equipment, transportation, personal emergency response, financial management, independent support brokerage, self-directed personal care, individual-directed goods and services, and self-directed community supports and employment. Providers enrolled to provide BI waiver services and each of their staff members involved in direct consumer service on or before December 31, 2014, shall be deemed to have completed the required training.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject

to review under subrule 77.39(11). Consumer-directed attendant care and interim medical monitoring and treatment providers must be at least 18 years of age.

In addition, behavioral programming, supported community living, and supported employment providers shall meet the outcome-based standards set forth below in subrules 77.39(1) and 77.39(2) evaluated according to subrules 77.39(8) to 77.39(10), and the requirements of subrules 77.39(3) to 77.39(7). Respite providers shall also meet the standards in subrule 77.39(1).

77.39(1) *Organizational standards (Outcome 1).* Organizational outcome-based standards for HCBS BI providers are as follows:

a. The organization demonstrates the provision and oversight of high-quality supports and services to consumers.

b. The organization demonstrates a defined mission commensurate with consumers' needs, desires, and abilities.

c. The organization establishes and maintains fiscal accountability.

d. The organization has qualified staff commensurate with the needs of the consumers they serve. These staff demonstrate competency in performing duties and in all interactions with clients.

e. The organization provides needed training and supports to its staff. This training includes at a minimum:

(1) Consumer rights.

(2) Confidentiality.

(3) Provision of consumer medication.

(4) Identification and reporting of child and dependent adult abuse.

(5) Individual consumer support needs.

f. The organization has a systematic, organizationwide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization:

(1) Measures and assesses organizational activities and services annually.

(2) Gathers information from consumers, family members, and staff.

(3) Conducts an internal review of consumer service records, including all major and minor incident reports according to subrule 77.37(8).

(4) Tracks incident data and analyzes trends annually to assess the health and safety of consumers served by the organization.

(5) Identifies areas in need of improvement.

(6) Develops a plan to address the areas in need of improvement.

(7) Implements the plan and documents the results.

g. Consumers and their legal representatives have the right to appeal the provider's implementation of the 20 outcomes, or staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

h. The provider shall have written policies and procedures and a staff training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The governing body has an active role in the administration of the agency.

j. The governing body receives and uses input from a wide range of local community interests and consumer representation and provides oversight that ensures the provision of high-quality supports and services to consumers.

77.39(2) *Rights and dignity.* Outcome-based standards for rights and dignity are as follows:

a. (Outcome 2) Consumers are valued.

b. (Outcome 3) Consumers live in positive environments.

c. (Outcome 4) Consumers work in positive environments.

d. (Outcome 5) Consumers exercise their rights and responsibilities.

e. (Outcome 6) Consumers have privacy.

f. (Outcome 7) When there is a need, consumers have support to exercise and safeguard their rights.

g. (Outcome 8) Consumers decide which personal information is shared and with whom.

h. (Outcome 9) Consumers make informed choices about where they work.

i. (Outcome 10) Consumers make informed choices on how they spend their free time.

j. (Outcome 11) Consumers make informed choices about where and with whom they live.

k. (Outcome 12) Consumers choose their daily routine.

l. (Outcome 13) Consumers are a part of community life and perform varied social roles.

m. (Outcome 14) Consumers have a social network and varied relationships.

n. (Outcome 15) Consumers develop and accomplish personal goals.

o. (Outcome 16) Management of consumers' money is addressed on an individualized basis.

p. (Outcome 17) Consumers maintain good health.

q. (Outcome 18) The consumer's living environment is reasonably safe in the consumer's home and community.

r. (Outcome 19) The consumer's desire for intimacy is respected and supported.

s. (Outcome 20) Consumers have an impact on the services they receive.

77.39(3) *The right to appeal.* Consumers and their legal representatives have the right to appeal the provider's application of policies or procedures, or any staff or contractual person's action which affects the consumer. The provider shall distribute the policies for consumer appeals and procedures to consumers.

77.39(4) *Storage and provision of medication.* If the provider stores, handles, prescribes, dispenses or administers prescription or over-the-counter medications, the provider shall develop procedures for the storage, handling, prescribing, dispensing or administration of medication. For controlled substances, procedures shall be in accordance with department of inspections and appeals rule 481—63.18(135).

77.39(5) *Research.* If the provider conducts research involving consumers, the provider shall have written policies and procedures addressing the research. These policies and procedures shall ensure that consumers' rights are protected.

77.39(6) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS brain injury waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

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

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.39(7) *Intake, admission, service coordination, discharge, and referral.*

a. The provider shall have written policies and procedures according to state and federal laws for intake, admission, service coordination, discharge and referral.

b. The provider shall ensure the rights of persons applying for services.

77.39(8) *Certification process.* Reviews of compliance with standards for initial certification and recertification shall be conducted by the department of human services' bureau of long-term care quality assurance staff. Certification carries no assurance that the approved provider will receive funding.

a. Rescinded IAB 9/1/04, effective 11/1/04.

b. Rescinded IAB 9/1/04, effective 11/1/04.

c. Rescinded IAB 9/1/04, effective 11/1/04.

d. The department may request any information from the prospective service provider which is considered pertinent to arriving at a certification decision. This may include, but is not limited to:

(1) Current accreditations, evaluations, inspections and reviews by regulatory and licensing agencies and associations.

(2) Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.39(9) *Initial certification.* The department shall review the application and accompanying information to see if the provider has the necessary framework to provide services in accordance with all applicable requirements and standards.

a. The department shall make a determination regarding initial certification within 60 days of receipt of the application and notify the provider in writing of the decision unless extended by mutual consent of the parties involved.

b. The decision of the department on initial certification of the providers shall be based on all relevant information, including:

(1) The application for status as an approved provider according to requirements of rules.

(2) A determination of the financial position of the prospective provider in relation to its ability to meet the stated need.

c. Providers applying for initial certification shall be offered technical assistance.

77.39(10) *Period of certification.* Provider certification shall become effective on the date identified on the certificate of approval and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

a. Initial certification. Providers eligible for initial certification by the department shall be issued an initial certification for 270 calendar days based on documentation provided.

b. Recertification. After the initial certification, the level of certification shall be based on an on-site review unless the provider has been accredited for similar services by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Quality and Leadership in Supports for People with Disabilities (The Council), or the Council on Accreditation of Services for Families and Children (COA). The on-site reviews for supported community living and supported employment use interviews with consumers and significant people in the consumer's life to determine whether or not the 20 individual value-based outcomes set forth in subrules 77.39(1) and 77.39(2) and corresponding processes are present for the consumer. Respite services are required to meet Outcome 1 and participate in satisfaction surveys.

Once the outcomes and processes have been determined for all the consumers in the sample, a review team then determines which of the 20 outcomes and processes are present for the provider. A specific outcome is present for the provider when the specific outcome is determined to be present for 75 percent or more of the consumers interviewed. A specific process is present for the provider when the process is determined to be present for 75 percent or more of the consumers interviewed. Since the processes are in the control of the provider and the outcomes are more in the control of the consumer, length of certification will be based more heavily on whether or not the processes are in place to help consumers obtain desired outcomes.

An exit conference shall be held with the organization to share preliminary findings of the certification review. A review report shall be written and sent to the provider within 30 calendar days unless the parties mutually agree to extend that time frame.

Provider certification shall become effective on the date identified on the Certificate of Approval, Form 470-3410, and shall terminate in 270 calendar days, one year, or three calendar years from the month of issue. The renewal of certification shall be contingent upon demonstration of continued compliance with certification requirements.

c. The department may issue four categories of recertification:

(1) *Three-year certification with excellence.* An organization is eligible for certification with excellence if the number of processes present is 18 or higher and the number of outcomes and corresponding processes present together is 12 or higher. Both criteria need to be met to receive

three-year certification with excellence. Corrective actions may be required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(2) *Three-year certification with follow-up monitoring.* An organization is eligible for this type of certification if the number of processes present is 17 or higher and the number of outcomes and corresponding processes present together is 11 or higher. Both criteria need to be met to receive three-year certification. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(3) *One-year certification.* An organization is eligible for this type of certification when the number of processes present is 14 or higher and the number of outcomes and processes present together is 9 or higher. Both criteria need to be met to receive one-year certification. One-year certification may also be given in lieu of longer certification when previously required corrective actions have not been implemented or completed. Corrective actions are required which may be monitored through the assignment of follow-up monitoring either by written report, a plan of corrective actions and improvements, an on-site review, or the provision of technical assistance.

(4) *Probational certification.* A probational certification may be issued to those providers who cannot meet requirements for a one-year certification. This time period shall be granted to the provider to establish and implement corrective actions and improvement activities. During this time period the department may require monitoring of the implementation of the corrective actions through on-site visits, written reports or technical assistance. Probational certification issued for 270 calendar days shall not be renewed or extended and shall require a full on-site follow-up review to be completed. The provider shall be required to achieve at least a one-year certification status at the time of the follow-up review in order to maintain certification.

d. During the course of the review, if a team member encounters a situation that places a consumer in immediate jeopardy, the team member shall immediately notify the provider, the department, and other team members. "Immediate jeopardy" refers to circumstances where the life, health, or safety of a member will be severely jeopardized if the circumstances are not immediately corrected.

(1) The provider shall correct the situation within 24 to 48 hours. If the situation is not corrected within the prescribed time frame, that portion of the provider's services that was the subject of the notification shall not be certified. The department shall immediately discontinue funding for that provider's service.

(2) If this action is appealed and the member, legal guardian, or attorney in fact under a durable power of attorney for health care wants to maintain the provider's services, funding can be reinstated. At that time the provider shall take appropriate action to ensure the life, health, and safety of the members deemed to be at risk as a result of the provider's inaction.

e. As a mandatory reporter, each team member shall be required to follow appropriate procedure in all cases where a condition reportable to child and adult protective services is observed.

f. The department may grant an extension to the period of approval for the following reasons:

(1) A delay in the department's approval decision which is beyond the control of the provider or department.

(2) A request for an extension from a provider to permit the provider to prepare and obtain department approval of corrective actions. The department shall establish the length of extensions on a case-by-case basis.

g. The department may revoke the provider's approval at any time for any of the following reasons:

(1) Findings of a site visit indicate that the provider has failed to implement the corrective actions submitted pursuant to paragraph 77.39(11)*"d."*

(2) The provider has failed to provide information requested pursuant to paragraph 77.39(11)*"e."*

(3) The provider refuses to allow the department to conduct a site visit pursuant to paragraph 77.39(11)*"f."*

(4) There are instances of noncompliance with the standards which were not identified from information submitted on the application.

h. An approved provider shall immediately notify the department, applicable county, or region, the applicable mental health and developmental disabilities planning council, and other interested parties of a decision to withdraw from an HCBS BI waiver service.

i. Following certification, any provider may request technical assistance from the department to bring into conformity those areas found in noncompliance with HCBS requirements. If multiple deficiencies are noted during a review, the department may require that technical assistance be provided to a provider to assist in the implementation of the provider's corrective actions. Providers may be given technical assistance as needed.

j. Appeals. Any adverse action can be appealed by the provider under 441—Chapter 7.

77.39(11) *Departmental reviews.* Reviews of compliance with standards as indicated in this chapter shall be conducted by the division of mental health and developmental disabilities quality assurance review staff. This review may include on-site case record audits, administrative procedures, clinical practices, and interviews with staff, consumers, and board of directors consistent with the confidentiality safeguards of state and federal laws.

a. Reviews shall be conducted annually with additional reviews conducted at the discretion of the department.

b. Following a departmental review, the department shall submit a copy of the department's determined survey report to the service provider, noting service deficiencies and strengths.

c. The service provider shall develop a plan of corrective action identifying completion time frames for each survey deficiency.

d. The corrective action plan shall be submitted to the Division of Mental Health and Developmental Disabilities, 5th Floor, Hoover State Office Building, Des Moines, Iowa 50319-0114, and include a statement dated and signed, if applicable, by the chief administrative officer and president or chairperson of the governing body that all information submitted to the department is accurate and complete.

e. The department may request the provider to supply subsequent reports on implementation of a corrective action plan submitted pursuant to paragraphs 77.39(11)*"c"* and *"d."*

f. The department may conduct a site visit to verify all or part of the information submitted.

77.39(12) *Case management service providers.* Case management provider organizations are eligible to participate in the Medicaid HCBS brain injury waiver program provided that they meet the standards in 441—Chapter 24 and they are the department of human services, a county or consortium of counties, or a provider under subcontract to the department or a county or consortium of counties.

77.39(13) *Supported community living providers.*

a. The department shall certify only public or private agencies to provide the supported community living service. The department does not recognize individuals as service providers under the supported community living program.

b. Providers of services meeting the definition of foster care shall also be licensed according to applicable 441—Chapters 108, 112, 114, 115, and 116, which deal with foster care licensing.

c. Providers of service may employ or contract with individuals meeting the definition of foster family homes to provide supported community living services. These individuals shall be licensed according to applicable 441—Chapters 112 and 113, which deal with foster care licensing.

d. The department shall approve living units designed to serve four consumers if the geographic location of the program does not result in an overconcentration of programs in an area.

(1) and (2) Rescinded IAB 8/7/02, effective 10/1/02.

e. The department shall approve living units designed to serve up to four persons except as necessary to prevent an overconcentration of supported community living units in a geographic area.

f. The department shall approve a living unit designed to serve five persons if both of the following conditions are met:

(1) Approval will not result in an overconcentration of supported community living units in a geographic area.

(2) The county in which the living unit is located provides to the bureau of long-term care verification in writing that the approval is needed to address one or more of the following issues:

1. The quantity of services currently available in the county is insufficient to meet the need;
2. The quantity of affordable rental housing in the county is insufficient to meet the need; or
3. Approval will result in a reduction in the size or quantity of larger congregate settings.

77.39(14) *Respite service providers.* Respite providers are eligible to be providers of respite service in the HCBS brain injury waiver if they have documented training or experience with persons with a brain injury.

a. The following agencies may provide respite services:

(1) Respite providers certified under the HCBS intellectual disability waiver.

(2) Adult day care providers that meet the conditions of participation set forth in subrule 77.39(20).

(3) Group living foster care facilities for children licensed by the department according to 441—Chapters 112 and 114 to 116 and child care centers licensed according to 441—Chapter 109.

(4) Camps certified by the American Camping Association.

(5) Home care agencies that meet the conditions of participation set forth in subrule 77.30(1).

(6) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

(7) Residential care facilities for persons with mental retardation licensed by the department of inspections and appeals.

(8) Home health agencies that are certified to participate in the Medicare program.

(9) Agencies certified by the department to provide respite services in the consumer's home that meet the requirements of subrules 77.39(1) and 77.39(3) through 77.39(7).

(10) Assisted living programs certified by the department of inspections and appeals.

b. Respite providers shall meet the following conditions:

(1) Providers shall maintain the following information that shall be updated at least annually:

1. The consumer's name, birth date, age, and address and the telephone number of each parent, guardian or primary caregiver.
2. An emergency medical care release.
3. Emergency contact telephone numbers such as the number of the consumer's physician and the parents, guardian, or primary caregiver.
4. The consumer's medical issues, including allergies.
5. The consumer's daily schedule which includes the consumer's preferences in activities or foods or any other special concerns.

(2) Procedures shall be developed for the dispensing, storage, authorization, and recording of all prescription and nonprescription medications administered. Home health agencies must follow Medicare regulations for medication dispensing.

All medications shall be stored in their original containers, with the accompanying physician's or pharmacist's directions and label intact. Medications shall be stored so they are inaccessible to consumers and the public. Nonprescription medications shall be labeled with the consumer's name.

In the case of medications that are administered on an ongoing, long-term basis, authorization shall be obtained for a period not to exceed the duration of the prescription.

(3) Policies shall be developed for:

1. Notifying the parent, guardian or primary caregiver of any injuries or illnesses that occur during respite provision. A parent's, guardian's or primary caregiver's signature is required to verify receipt of notification.
2. Requiring the parent, guardian or primary caregiver to notify the respite provider of any injuries or illnesses that occurred prior to respite provision.
3. Documenting activities and times of respite. This documentation shall be made available to the parent, guardian or primary caregiver upon request.
4. Ensuring the safety and privacy of the individual. Policies shall at a minimum address threat of fire, tornado, or flood and bomb threats.

c. A facility providing respite under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in locations consistent with licensure.

d. Respite provided outside the consumer's home or the facility covered by the licensure, certification, accreditation, or contract must be approved by the parent, guardian or primary caregiver and the interdisciplinary team and must be consistent with the way the location is used by the general public. Respite in these locations shall not exceed 72 continuous hours.

77.39(15) *Supported employment providers.*

a. The following agencies may provide supported employment services:

(1) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider, a community employment service provider or a provider of a similar service.

(2) An agency that is accredited by the Council on Accreditation for similar services.

(3) An agency that is accredited by the Joint Commission for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership for similar services.

(5) An agency that is accredited by the International Center for Clubhouse Development.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Individuals may not provide supported employment services except when the services are purchased through the consumer choices option.

d. Direct support staff providing individual or small-group supported employment or long-term job coaching services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) Individual supported employment: bachelor's degree or commensurate experience, preferably in human services, sociology, psychology, education, human resources, marketing, sales or business. The person must also hold a nationally recognized certification (ACRE or College of Employment Services (CES) or similar) as an employment specialist or must earn this credential within 24 months of hire.

(2) Long-term job coaching: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(3) Small-group supported employment: associate degree, or high school diploma or equivalent and 6 months' relevant experience. A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the ACRE certified training program. The person must also hold or obtain, within 24 months of hire, nationally recognized certification in job training and coaching.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.39(16) *Home and vehicle modification providers.* The following providers may provide home and vehicle modification:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver, enrolled as home and vehicle modification providers under the physical disability waiver, or certified as home and vehicle modification providers under the physical disability waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.39(17) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

a. Providers shall be certified annually.

b. The service provider shall submit documentation to the department supporting continued compliance with the requirements set forth in subrule 77.33(2) 90 days before the expiration of the current certification.

77.39(18) *Transportation service providers.* This service is not to be provided at the same time as supported community service, which includes transportation. The following providers may provide transportation:

a. Area agencies on aging as designated in rule 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Providers with purchase of service contracts to provide transportation pursuant to 441—Chapter 150.

e. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

f. Transportation providers contracting with the nonemergency medical transportation contractor.

77.39(19) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.43(8).

77.39(20) *Adult day care providers.* Adult day care providers shall be agencies that are certified by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

77.39(21) *Family counseling and training providers.* Family counseling and training providers shall be one of the following:

a. Providers certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

b. Providers licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules in 481—Chapter 53 or certified to meet the standards under the Medicare program for hospice programs, and that employ staff who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

c. Providers accredited under the mental health service provider standards established by the mental health and developmental and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV, and that employ staff to provide family counseling and training who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

d. Individuals who meet the definition of qualified brain injury professional as set forth in rule 441—83.81(249A).

e. Agencies certified as brain injury waiver providers pursuant to rule 441—77.39(249A) that employ staff to provide family counseling who meet the definition of a qualified brain injury professional as set forth in rule 441—83.81(249A).

77.39(22) *Prevocational services providers.*

a. Providers of prevocational services must be accredited by one of the following:

(1) The Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(2) The Council on Quality and Leadership accreditation in supports for people with disabilities.

b. Providers responsible for the payroll of members shall have policies that ensure compliance with state and federal labor laws and regulations, which include, but are not limited to:

(1) Subminimum wage laws and regulations, including the Workforce Investment Opportunity Act.

(2) Member vacation, sick leave and holiday compensation.

(3) Procedures for payment schedules and pay scale.

(4) Procedures for provision of workers' compensation insurance.

(5) Procedures for the determination and review of commensurate wages.

c. Direct support staff providing prevocational services shall meet the following minimum qualifications in addition to other requirements outlined in administrative rule:

(1) A person providing direct support without line-of-sight supervision shall be at least 18 years of age and possess a high school diploma or equivalent. A person providing direct support with line-of-sight supervision shall be 16 years of age or older.

(2) A person providing direct support shall not be an immediate family member of the member.

(3) A person providing direct support shall, within 6 months of hire or within 6 months of May 4, 2016, complete at least 9.5 hours of employment services training as offered through DirectCourse or through the Association of Community Rehabilitation Educators (ACRE) certified training program.

(4) Supported employment direct support staff shall complete 4 hours of continuing education in employment services annually.

77.39(23) *Behavioral programming providers.* Behavioral programming providers shall be required to have experience with or training regarding the special needs of persons with a brain injury. In addition, they must meet the following requirements.

a. Behavior assessment, and development of an appropriate intervention plan, and periodic reassessment of the plan, and training of staff who shall implement the plan must be done by a qualified brain injury professional as defined in rule 441—83.81(249A). Formal assessment of the consumers' intellectual and behavioral functioning must be done by a licensed psychologist or a psychiatrist who is certified by the American Board of Psychiatry.

b. Implementation of the plan and training and supervision of caregivers, including family members, must be done by behavioral aides who have been trained by a qualified brain injury professional as defined in rule 441—83.81(249A) and who are employees of one of the following:

(1) Agencies which are certified under the community mental health center standards established by the mental health and developmental disabilities commission, set forth in 441—Chapter 24, Divisions I and III.

(2) Agencies which are licensed as meeting the hospice standards and requirements set forth in department of inspections and appeals rules 481—Chapter 53 or which are certified to meet the standards under the Medicare program for hospice programs.

(3) Agencies which are accredited under the mental health service provider standards established by the mental health and disabilities commission, set forth in 441—Chapter 24, Divisions I and IV.

(4) Home health aide providers meeting the standards set forth in subrule 77.33(3). Home health aide providers certified by Medicare shall be considered to have met these standards.

(5) Brain injury waiver providers certified pursuant to rule 441—77.39(249A).

77.39(24) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide attendant care service and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies which are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.93.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.39(25) *Interim medical monitoring and treatment providers.*

a. The following providers may provide interim medical monitoring and treatment services:

(1) Home health agencies certified to participate in the Medicare program.

(2) Supported community living providers certified according to subrule 77.37(14) or 77.39(13).

b. Staff requirements. Staff members providing interim medical monitoring and treatment services to members shall meet all of the following requirements:

(1) Be at least 18 years of age.

(2) Not be the spouse of the member or a parent or stepparent of the member if the member is aged 17 or under.

(3) Not be a usual caregiver of the member.

(4) Be qualified by training or experience to provide medical intervention or intervention in a medical emergency necessary to carry out the member's plan of care. The training or experience required must be determined by the member's usual caregivers and a licensed medical professional on the member's interdisciplinary team and must be documented in the member's service plan.

c. Service documentation. Providers shall maintain clinical and fiscal records necessary to fully disclose the extent of services furnished to members. Records shall specify by service date the procedures performed, together with information concerning progress of treatment.

77.39(26) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.39(27) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.39(28) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.39(29) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.39(30) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the requirements in subrule 77.30(17).

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 1638C**, IAB 10/1/14, effective 11/5/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16]

441—77.40(249A) Lead inspection agencies. The Iowa department of public health and agencies certified by the Iowa department of public health pursuant to 641—subrule 70.5(5) are eligible to participate in the Medicaid program as providers of lead inspection services.

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

441—77.41(249A) HCBS physical disability waiver service providers. Providers shall be eligible to participate in the Medicaid physical disability waiver program if they meet the requirements in this rule and the subrules applicable to the individual service. Enrolled providers shall maintain the certification listed in the applicable subrules in order to remain eligible providers.

Services shall be rendered by a person who is at least 16 years old (except as otherwise provided in this rule) and is not the spouse of the consumer served or the parent or stepparent of a consumer aged 17 or under. People who are 16 or 17 years old must be employed and supervised by an enrolled HCBS provider unless they are employed to provide self-directed personal care services through the

consumer choices option. A person hired for self-directed personal care services need not be supervised by an enrolled HCBS provider. A person hired through the consumer choices option for independent support brokerage, self-directed personal care, individual-directed goods and services, or self-directed community support and employment is not required to enroll as a Medicaid provider and is not subject to the requirements of subrule 77.41(1).

77.41(1) *Enrollment process.* Reviews of compliance with standards for initial enrollment shall be conducted by the department's quality assurance staff. Enrollment carries no assurance that the approved provider will receive funding.

Review of a provider may occur at any time.

The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This may include, but is not limited to:

a. Current accreditations, evaluations, inspection reports, and reviews by regulatory and licensing agencies and associations.

b. Fiscal capacity of the prospective provider to initiate and operate the specified programs on an ongoing basis.

77.41(2) *Consumer-directed attendant care providers.* The following providers may provide consumer-directed attendant care service:

a. An individual who contracts with the member to provide consumer-directed attendant care and who is:

(1) At least 18 years of age.

(2) Qualified by training or experience to carry out the member's plan of care pursuant to the department-approved case plan or individual comprehensive plan.

(3) Not the spouse or guardian of the member or a parent or stepparent of a member aged 17 or under.

(4) Not the recipient of respite services paid through home- and community-based services on behalf of a member who receives home- and community-based services.

b. Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

c. Home health agencies that are certified to participate in the Medicare program.

d. Chore providers subcontracting with area agencies on aging or with letters of approval from the area agencies on aging stating that the organization is qualified to provide chore services.

e. Community action agencies as designated in Iowa Code section 216A.103.

f. Providers certified under an HCBS waiver for supported community living.

g. Assisted living programs that are certified by the department of inspections and appeals under 481—Chapter 69.

h. Adult day service providers that are certified by the department of inspections and appeals under 481—Chapter 70.

77.41(3) *Home and vehicle modification providers.* The following providers may provide home and vehicle modifications:

a. Providers eligible to participate as home and vehicle modification providers under the elderly or health and disability waiver or certified as home and vehicle modification providers under the home- and community-based services intellectual disability or brain injury waiver.

b. Community businesses that have all necessary licenses and permits to operate in conformity with federal, state, and local laws and regulations and that submit verification of current liability and workers' compensation insurance.

77.41(4) *Personal emergency response system providers.* Personal emergency response system providers shall be agencies which meet the conditions of participation set forth in subrule 77.33(2).

77.41(5) *Specialized medical equipment providers.* The following providers may provide specialized medical equipment:

a. Medical equipment and supply dealers participating as providers in the Medicaid program.

b. Retail and wholesale businesses participating as providers in the Medicaid program which provide specialized medical equipment as defined in 441—subrule 78.46(4).

77.41(6) *Transportation service providers.* The following providers may provide transportation:

a. Area agencies on aging as designated in 17—4.4(231) or with letters of approval from the area agencies on aging stating the organization is qualified to provide transportation services.

b. Community action agencies as designated in Iowa Code section 216A.93.

c. Regional transit agencies as recognized by the Iowa department of transportation.

d. Nursing facilities licensed pursuant to Iowa Code chapter 135C.

e. Transportation providers contracting with the nonemergency medical transportation contractor.

77.41(7) *Financial management service.* Consumers who elect the consumer choices option shall work with a financial institution that meets the qualifications in subrule 77.30(13).

77.41(8) *Independent support brokerage.* Consumers who elect the consumer choices option shall work with an independent support broker who meets the qualifications in subrule 77.30(14).

77.41(9) *Self-directed personal care.* Consumers who elect the consumer choices option may choose to purchase self-directed personal care services from an individual or business that meets the requirements in subrule 77.30(15).

77.41(10) *Individual-directed goods and services.* Consumers who elect the consumer choices option may choose to purchase individual-directed goods and services from an individual or business that meets the requirements in subrule 77.30(16).

77.41(11) *Self-directed community supports and employment.* Consumers who elect the consumer choices option may choose to purchase self-directed community supports and employment from an individual or business that meets the subrule requirements in 77.30(17).

77.41(12) *Incident management and reporting.* As a condition of participation in the medical assistance program, HCBS physical disability waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and with the incident management and reporting requirements in this subrule. EXCEPTION: The conditions in this subrule do not apply to providers of goods and services purchased under the consumer choices option or providers of home and vehicle modification, specialized medical equipment, personal emergency response, and transportation.

a. Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or
7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

b. Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's

supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

c. Reporting procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident:

(1) The staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.

2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.

3. The consumer's case manager.

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

1. By direct data entry into the Iowa Medicaid Provider Access System, or

2. By faxing or mailing Form 470-4698, Critical Incident Report, according to the directions on the form.

(3) The following information shall be reported:

1. The name of the consumer involved.

2. The date and time the incident occurred.

3. A description of the incident.

4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.

5. The action that the provider staff took to manage the incident.

6. The resolution of or follow-up to the incident.

7. The date the report is made and the handwritten or electronic signature of the person making the report.

(4) Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about the incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

d. Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

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

[**ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.42(249A) Public health agencies. Public health agencies are eligible to participate in the medical assistance program when they serve as a public health entity within the local board of health jurisdiction pursuant to 641—subrule 77.3(3).

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

[**ARC 0358C**, IAB 10/3/12, effective 11/7/12]

441—77.43(249A) Infant and toddler program providers. An agency is eligible to participate in the medical assistance program as a provider of infant and toddler program services under rule 441—78.49(249A) if the agency:

1. Is in good standing under the infants and toddlers with disabilities program administered by the department of education, the department of public health, the department of human services, and the Iowa Child Health Specialty Clinics pursuant to the interagency agreement between these agencies under Subchapter III of the federal Individuals with Disabilities Education Act (IDEA); and

2. Meets the following additional requirements.

77.43(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.43(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation of services provided in the child's record. Documentation of all services performed is required and must include:

a. Date, time, location, and description of each service provided and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. An individual family service plan (IFSP) including all changes and revisions, as developed by the service coordinator pursuant to rule 281—41.5(256B,34CFR300).

d. Documentation of progress toward achieving the child's or family's action steps and outcomes as identified in the individual family service plan (IFSP).

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

441—77.44(249A) Local education agency services providers. School districts accredited by the department of education pursuant to 281—Chapter 12, the Iowa Braille and Sight Saving School governed by the state board of regents pursuant to Iowa Code section 262.7(4), and the State School for the Deaf governed by the state board of regents pursuant to Iowa Code section 262.7(5) are eligible to participate in the medical assistance program as providers of local education agency (LEA) services under rule 441—78.50(249A) if the following conditions are met.

77.44(1) *Licensure.* Covered services shall be provided by personnel who are licensed, endorsed, registered, recognized, or qualified as provided in this subrule and shall be within the scope of the applicable license, endorsement, registration, recognition, or qualification.

a. Personnel providing audiological or speech-language services shall be licensed by the Iowa board of speech pathology and audiology as a speech pathologist or audiologist pursuant to 645—Chapters 299, 300 and 303 through 305.

b. Personnel providing physical therapy shall be licensed by the Iowa board of physical and occupational therapy as a physical therapist pursuant to 645—Chapters 199 through 204.

c. Personnel providing occupational therapy shall be licensed by the Iowa board of physical and occupational therapy as an occupational therapist pursuant to 645—Chapters 205 through 210.

d. Personnel providing psychological evaluations and counseling or psychotherapy services shall be:

(1) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(2) Licensed by the Iowa board of psychology as a psychologist pursuant to 645—Chapters 239 through 243;

(3) Licensed by the Iowa board of social work as a social worker pursuant to 645—Chapters 279 through 284;

(4) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(5) Registered by the Iowa nursing board as an advanced registered nurse practitioner pursuant to 655—Chapter 7.

e. Personnel providing nursing services shall be licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6.

f. Personnel providing vision services shall be:

(1) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6;

(2) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11; or

(3) Licensed by the Iowa board of optometry as an optometrist pursuant to 645—Chapter 180.

g. Developmental services shall be provided by personnel who meet standards established pursuant to department of education rule 281—120.19(34CFR303).

h. Medical transportation shall be provided by licensed drivers.

i. Other services shall be provided by staff who are:

(1) Recognized as a special education paraprofessional pursuant to department of education rule 281—41.403(256B);

(2) Endorsed by the Iowa board of educational examiners as a school psychologist pursuant to rule 282—15.11(272);

(3) Endorsed by the Iowa board of educational examiners as a speech-language pathologist pursuant to rule 282—15.12(272);

(4) Endorsed by the Iowa board of educational examiners as an orientation and mobility specialist pursuant to rule 282—15.15(272);

(5) Endorsed by the Iowa board of educational examiners as a school occupational therapist pursuant to rule 282—15.16(272);

(6) Endorsed by the Iowa board of educational examiners as a school physical therapist pursuant to rule 282—15.17(272);

(7) Endorsed by the Iowa board of educational examiners as a special education nurse pursuant to rule 282—15.18(272);

(8) Endorsed by the Iowa board of educational examiners as a school social worker pursuant to rule 282—15.19(272);

(9) Licensed by the Iowa nursing board as a registered or licensed practical nurse pursuant to 655—Chapters 3 through 6; or

(10) Licensed by the Iowa board of medicine as a physician pursuant to 653—Chapters 9 through 11.

77.44(2) *Documentation requirements.* As a condition of participation, the provider shall be responsible for maintaining accurate and current documentation in the child's record. Documentation of all services performed is required and must include:

a. Date, time, duration, location, and description of each service delivered and identification of the individual rendering the service by name and professional or paraprofessional designation.

b. An assessment and response to interventions and services.

c. Progress toward goals in the individual education plan (IEP) or individual health plan (IHP) pursuant to 281—Chapter 41, Division VIII, or 281—subrule 41.96(1).

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

441—77.45(249A) Indian health facilities. A health care facility operated by the U.S. Indian Health Service or under the Indian Self-Determination and Education Assistance Act (P.L. 93-638) by an "Indian tribe," "tribal organization," or "Urban Indian organization," as those terms are defined in 25 U.S.C. 1603, is eligible to participate in the medical assistance program if the following conditions are met:

77.45(1) *Licensure.* Services must be rendered by practitioners who meet applicable professional licensure requirements.

77.45(2) *Documentation.* Medical records must be maintained at the same standards as are required for the applicable licensed medical practitioner.

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

[**ARC 2930C**, IAB 2/1/17, effective 4/1/17]

441—77.46(249A) HCBS children's mental health waiver service providers. HCBS children's mental health waiver services shall be rendered by provider agencies that meet the general provider

standards in subrule 77.46(1) and also meet the standards in subrules 77.46(2) to 77.46(5) that are specific to the waiver services provided. A provider that is approved for the same service under another HCBS Medicaid waiver shall be eligible to enroll for that service under the children's mental health waiver.

77.46(1) *General provider standards.* All providers of HCBS children's mental health waiver services shall meet the following standards:

a. Fiscal capacity. Providers must demonstrate the fiscal capacity to provide services on an ongoing basis.

b. Direct care staff.

(1) Direct care staff must be at least 18 years of age.

(2) Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 249A.29 before employment of a staff member who will provide direct care.

(3) Direct care staff may not be the spouse of the consumer or the parent or stepparent of the consumer.

c. Outcome-based standards and quality assurance.

(1) Providers shall implement the following outcome-based standards for the rights and dignity of children with serious emotional disturbance:

1. Consumers are valued.
2. Consumers are a part of community life.
3. Consumers develop meaningful goals.
4. Consumers maintain physical and mental health.
5. Consumers are safe.
6. Consumers and their families have an impact on the services received.

(2) The department's quality assurance staff shall conduct random quality assurance reviews to assess the degree to which the outcome-based standards have been implemented in service provision. Results of outcome-based quality assurance reviews shall be forwarded to the certifying or accrediting entity.

(3) A quality assurance review shall include interviews with the consumer and the consumer's parents or legal guardian, with informed consent, and interviews with designated targeted case managers.

(4) A quality assurance review may include interviews with provider staff, review of case files, review of staff training records, review of compliance with the general provider standards in this subrule, and review of other organizational policies and procedures and documentation.

(5) Corrective action shall be required if the quality assurance review demonstrates that service provision or provider policies and procedures do not reflect the outcome-based standards. Technical assistance for corrective action shall be available from the department's quality assurance staff.

d. Incident management and reporting. As a condition of participation in the medical assistance program, HCBS children's mental health waiver service providers must comply with the requirements of Iowa Code sections 232.69 and 235B.3 regarding the reporting of child abuse and dependent adult abuse and must comply with the following incident management and reporting requirements. EXCEPTION: The conditions in this paragraph do not apply to providers of environmental modifications and adaptive devices.

(1) Definitions.

"Major incident" means an occurrence involving a consumer during service provision that:

1. Results in a physical injury to or by the consumer that requires a physician's treatment or admission to a hospital;
2. Results in the death of any person;
3. Requires emergency mental health treatment for the consumer;
4. Requires the intervention of law enforcement;
5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3;

6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or

7. Involves a consumer's location being unknown by provider staff who are assigned protective oversight.

"Minor incident" means an occurrence involving a consumer during service provision that is not a major incident and that:

1. Results in the application of basic first aid;
2. Results in bruising;
3. Results in seizure activity;
4. Results in injury to self, to others, or to property; or
5. Constitutes a prescription medication error.

(2) Reporting procedure for minor incidents. Minor incidents may be reported in any format designated by the provider. When a minor incident occurs or a staff member becomes aware of a minor incident, the staff member involved shall submit the completed incident report to the staff member's supervisor within 72 hours of the incident. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(3) Notification procedure for major incidents. When a major incident occurs or a staff member becomes aware of a major incident, the staff member involved shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The staff member's supervisor.
2. The consumer or the consumer's legal guardian. EXCEPTION: Notification to the consumer is required only if the incident took place outside of the provider's service provision. Notification to the guardian, if any, is always required.
3. The consumer's case manager.

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

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

(5) Information to be reported. The following information shall be reported about a major incident:

1. The name of the consumer involved.
2. The date and time the incident occurred.
3. A description of the incident.
4. The names of all provider staff and others who were present at the time of the incident or who responded after becoming aware of the incident. The confidentiality of other waiver-eligible or non-waiver-eligible consumers who were present must be maintained by the use of initials or other means.
5. The action that the provider staff took to manage the incident.
6. The resolution of or follow-up to the incident.
7. The date the report is made and the handwritten or electronic signature of the person making the report.

(6) Response to report. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager. When complete information about a major incident is not available at the time of the initial report, the provider must submit follow-up reports until the case manager is satisfied with the incident resolution and follow-up. The completed report shall be maintained in a centralized file with a notation in the consumer's file.

(7) Tracking and analysis. The provider shall track incident data and analyze trends to assess the health and safety of consumers served and determine if changes need to be made for service implementation or if staff training is needed to reduce the number or severity of incidents.

77.46(2) *Environmental modifications, adaptive devices, and therapeutic resources providers.* The following agencies may provide environmental modifications, adaptive devices, and therapeutic resources under the children's mental health waiver:

a. A community business that:

(1) Possesses all necessary licenses and permits to operate in conformity with federal, state, and local statutes and regulations, including Iowa Code chapter 490; and

(2) Submits verification of current liability and workers' compensation insurance.

b. A retail or wholesale business that otherwise participates as a provider in the Medicaid program.

c. A home and vehicle modification provider enrolled under another HCBS Medicaid waiver.

d. A provider enrolled under the HCBS home- and community-based services intellectual disability or brain injury waiver as a supported community living provider.

e. A provider enrolled under the HCBS children's mental health waiver as a family and community support services provider.

77.46(3) *Family and community support services providers.*

a. *Qualified providers.* The following agencies may provide family and community support services under the children's mental health waiver:

(1) Behavioral health intervention providers qualified under 441—77.12(249A).

(2) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

b. *Staff training.* The agency shall meet the following training requirements as a condition of providing family and community support services under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.36(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. *Support of crisis intervention plan.* As a condition of providing services under the children's mental health waiver, a family and community support provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, a family and community support provider shall have written policies and procedures for intake, admission, and discharge.

77.46(4) *In-home family therapy providers.*

a. Qualified providers. The following agencies may provide in-home family therapy under the children's mental health waiver:

(1) Community mental health centers accredited in good standing as providers of outpatient psychotherapy and counseling under 441—Chapter 24.

(2) Mental health professionals licensed pursuant to 645—Chapter 31, 240, or 280 or possessing an equivalent license in another state.

b. Staff training. The agency shall meet the following training requirements as a condition of providing in-home family therapy under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity found in 77.46(1)*"c"* for the children's mental health waiver.

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and service provision to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the presence of experienced staff.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

d. Intake, admission, and discharge. As a condition of providing services under the children's mental health waiver, an in-home family therapy provider shall have written policies and procedures for intake, admission, and discharge.

77.46(5) *Respite care providers.*

a. Qualified providers. The following agencies may provide respite services under the children's mental health waiver:

(1) Providers certified or enrolled as respite providers under another Medicaid HCBS waiver.

(2) Group living foster care facilities for children licensed in good standing by the department according to 441—Chapters 112 and 114 to 116.

(3) Camps certified in good standing by the American Camping Association.

(4) Home health agencies that are certified in good standing to participate in the Medicare program.

(5) Agencies authorized to provide similar services through a contract with the department of public health (IDPH) for local public health services. The agency must provide a current IDPH local public health services contract number.

(6) Adult day care providers that are certified in good standing by the department of inspections and appeals as being in compliance with the standards for adult day services programs at 481—Chapter 70.

(7) Assisted living programs certified in good standing by the department of inspections and appeals.

(8) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(9) Nursing facilities, intermediate care facilities for the mentally retarded, and hospitals enrolled as providers in the Iowa Medicaid program.

b. Staff training. The agency shall meet the following training requirements as a condition of providing respite care under the children's mental health waiver:

(1) Within one month of employment, staff members must receive the following training:

1. Orientation regarding the agency's mission, policies, and procedures; and

2. Orientation regarding HCBS philosophy and outcomes for rights and dignity for the children's mental health waiver in 77.46(1)*"c."*

(2) Within four months of employment, staff members must receive training regarding the following:

1. Serious emotional disturbance in children and provision of services to children with serious emotional disturbance;

2. Confidentiality;

3. Provision of medication according to agency policy and procedure;

4. Identification and reporting of child abuse;

5. Incident reporting;

6. Documentation of service provision;

7. Appropriate behavioral interventions; and

8. Professional ethics.

(3) Until a staff member receives the training identified in subparagraphs (1) and (2), the staff member shall not provide any direct service without the oversight of supervisory staff and shall obtain feedback from the family within 24 hours of service provision.

(4) Within the first year of employment, staff members must complete 24 hours of training in children's mental health issues.

(5) During each consecutive year of employment, staff members must complete 12 hours of training in children's mental health issues.

c. Consumer-specific information. The following information must be written, current, and accessible to the respite provider during service provision:

(1) The consumer's legal and preferred name, birth date, and age, and the address and telephone number of the consumer's usual residence.

(2) The consumer's typical schedule.

(3) The consumer's preferences in activities and foods or any other special concerns.

(4) The consumer's crisis intervention plan.

d. Written notification of injury. The respite provider shall inform the parent, guardian or usual caregiver that written notification must be given to the respite provider of any recent injuries or illnesses that have occurred before respite provision.

e. Medication dispensing. Respite providers shall develop policies and procedures for the dispensing, storage, and recording of all prescription and nonprescription medications administered during respite provision. Home health agencies must follow Medicare regulations regarding medication dispensing.

f. Support of crisis intervention plan. As a condition of providing services under the children's mental health waiver, a respite provider shall develop and implement policies and procedures for maintaining the integrity of the individualized crisis intervention plan as defined in 441—24.1(225C) that is developed by each consumer's interdisciplinary team. The policies and procedures shall address:

(1) Sharing with the case manager and the interdisciplinary team information pertinent to the development of the consumer's crisis intervention plan.

(2) Training staff before service provision, in cooperation with the consumer's parents or legal guardian, regarding the consumer's individual mental health needs and individualized supports as identified in the crisis intervention plan.

(3) Ensuring that all staff have access to a written copy of the most current crisis intervention plan during service provision.

(4) Ensuring that the plan contains current and accurate information by updating the case manager within 24 hours regarding any circumstance or issue that would have an impact on the consumer's mental health or change the consumer's crisis intervention plan.

g. Service documentation. Documentation of respite care shall be made available to the consumer, parents, guardian, or usual caregiver upon request.

h. Capacity. A facility providing respite care under this subrule shall not exceed the facility's licensed capacity, and services shall be provided in a location and for a duration consistent with the facility's licensure.

i. Service provided outside home or facility. For respite care to be provided in a location other than the consumer's home or the provider's facility:

(1) The care must be approved by the parent, guardian or usual caregiver;

(2) The care must be approved by the interdisciplinary team in the consumer's service plan;

(3) The care must be consistent with the way the location is used by the general public; and

(4) Respite care in these locations shall not exceed 72 continuous hours.

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 7936B**, IAB 7/1/09, effective 9/1/09; **ARC 9314B**, IAB 12/29/10, effective 3/1/11; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1149C**, IAB 10/30/13, effective 1/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.47(249A) Health home services providers. Subject to the requirements of this rule, a designated provider may participate in the medical assistance program as a provider of health home services.

77.47(1) *Qualifications.* A designated provider of health home services must be a Medicaid-enrolled entity or provider that is determined through the provider enrollment process to have the systems and infrastructure in place to provide health home services.

a. Staffing. At a minimum, a qualifying provider must fill the following roles:

(1) Designated practitioner.

(2) Dedicated care coordinator.

(3) Health coach.

(4) Clinic support staff.

b. Data management. A qualifying provider shall ensure that all clinical data related to the member are maintained with the member's medical records through the use of health information technology.

c. Collaboration with case managers. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)*"a"*(1) or (2) must collaborate, at least quarterly, with targeted case managers, other case managers, or DHS service workers for each member receiving case management services. Strategies to prevent duplication of coordination efforts by the health home and case managers or service workers must be developed by the health home and documented upon request. Documentation may include but is not limited to records of joint staffing meetings where a member's medical needs, current activities, and waiver services needs are reviewed and appropriately updated.

d. Provision of integrated health home services. Health homes providing services to members eligible pursuant to 441—subparagraph 78.53(2)*"a"*(3) or (4) must be integrated health homes that:

(1) Consist of a team of health care professionals trained in providing health home services to members with a serious mental illness (SMI) and to members with a serious emotional disturbance (SED);

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

(3) Coordinate all community and social support services needs for members enrolled in the health home; and

(4) Follow a system of care model in providing health home services to members with SED, including collaboration with the child welfare, public health, juvenile justice, and education systems.

77.47(2) *Report on quality measures.* As a condition of participation in the medical assistance program as a provider of health home services and of receiving payment for health home services provided, a designated provider must report to the Iowa Medicaid enterprise on measures for determining the quality of such services. When appropriate and feasible, a designated provider shall use health information technology in providing the Iowa Medicaid enterprise with such information.

77.47(3) *Selection.* As a condition of payment for health home services provided to a Medicaid member eligible to receive such services pursuant to 441—subrule 78.53(2), a designated provider must be selected by the member as the member's health home, as reported by provider attestation.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.

[**ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0838C**, IAB 7/24/13, effective 7/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.48(249A) Speech-language pathologists. Speech-language pathologists who are enrolled in the Medicare program are eligible to participate in Medicaid. Speech-language pathologists who are not enrolled in the Medicare program are eligible to participate in Medicaid if they are licensed and in independent practice, as an individual or as a group.

77.48(1) Speech-language pathologists in another state are eligible to participate if they are licensed in that state and meet the Medicare criteria for enrollment.

77.48(2) Speech-language pathologists who provide services to Medicaid members who are also Medicare beneficiaries must be enrolled in the Medicare program.

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.

[**ARC 0360C**, IAB 10/3/12, effective 12/1/12]

441—77.49(249A) Physician assistants. All physician assistants licensed to practice in the state of Iowa are eligible for participation in the program. Physician assistants duly licensed to practice in other states are also eligible for participation. Enrollment is for the purpose of providing professional services for Medicaid members including orders and referrals, as required under Public Law 111-148, Section 6401,

otherwise known as the Patient Protection and Affordable Care Act (PPACA). Enrollment will not affect the provider's payment arrangements with facilities or supervising providers.

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

[**ARC 0580C**, IAB 2/6/13, effective 4/1/13]

441—77.50(249A) Ordering and referring providers. A provider who provides services, including orders and referrals, to a Medicaid member shall be enrolled as a Medicaid provider as a condition of payment eligibility for services rendered to that Medicaid member. A provider who does not individually bill for services rendered due to, for example, payment arrangements with a facility or supervising provider, shall also be required to enroll. Enrollment will be for the purpose of ordering or referring items and providing professional services to Medicaid members and will not affect the provider's payment arrangements with such facilities or supervising providers.

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

[**ARC 0580C**, IAB 2/6/13, effective 4/1/13]

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

[**ARC 1698C**, IAB 10/29/14, effective 1/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—77.52(249A) Community-based neurobehavioral rehabilitation services.

77.52(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" means services provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's needs.

77.52(2) *Eligible providers.* The following agencies may provide community-based neurobehavioral rehabilitation residential and intermittent services:

a. An organization that is accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider.

b. Agencies not accredited by a department-approved, nationally recognized accreditation organization as a specialty brain injury rehabilitation service provider that have applied for accreditation within the last 16 months to provide services may be enrolled. However, an organization that has not received accreditation within 16 months after application shall no longer be a qualified provider.

77.52(3) *Provider standards.* All community-based neurobehavioral rehabilitation service providers shall meet the following criteria:

a. The organization meets the outcome-based standards for community-based neurobehavioral rehabilitation service providers as follows:

(1) The organization shall provide high-quality supports and services to members.

(2) The organization shall have a defined mission commensurate with members' needs, desires, and abilities.

(3) The organization shall be fiscally sound and shall establish and maintain fiscal accountability.

(4) The program administrator shall be a certified brain injury specialist trainer (CBIST) through the Academy of Certified Brain Injury Specialists or a certified brain injury specialist under the direct supervision of a CBIST or a qualified brain injury professional as defined in rule 441—83.81(249A) with additional certification as approved by the department.

(5) A minimum of 75 percent of the organization's administrative and direct care personnel shall meet one of the following criteria:

1. Have a bachelor's degree in a human services-related field;

2. Have an associate's degree in human services with two years of experience working with individuals with brain injury;

3. Be an individual who is in the process of seeking a degree in the human services field with two years of experience working with individuals with brain injury; or

4. Be a certified brain injury specialist or have other brain injury certification as approved by the department.

(6) The organization shall have qualified personnel trained in the provision of direct care services to people with a brain injury. The training must be commensurate with the needs of the members served. Employees shall receive training and demonstrate competency in performing assigned duties and in all interactions with members, including but not limited to:

1. Promotion of a program structure and support for persons served so they can re-learn or regain skills for community inclusion and access.

2. Compensatory strategies to assist in managing ADLS (activities of daily living).

3. Quality of life issues.

4. Behavioral supports and identification of antecedent triggers.

5. Health and medication management.

6. Dietary and nutritional programming.

7. Assistance with identifying and utilizing assistive technology.

8. Substance abuse and addiction issues.

9. Self-management and self-interaction skills.

10. Flexibility in programming to meet members' individual needs.

11. Teaching adaptive and compensatory strategies to address cognitive, behavioral, physical, psychosocial and medical needs.

12. Community accessibility and safety.

13. Household maintenance.

14. Service support to the member's family or support system related to the member's neurobehavioral care.

b. The organization provides training and supports to its personnel. Training shall be provided before direct service provision and must be ongoing. At a minimum the training includes the following:

(1) Completion of the department-approved brain injury training modules.

(2) Member rights.

(3) Confidentiality and privacy.

(4) Dependent adult and child abuse prevention and mandatory reporter training.

(5) Individualized rehabilitation treatment plans.

(6) Major mental health disorder basics.

c. Within 30 days of commencement of direct service provision, employees shall complete cardiopulmonary resuscitation (CPR) training, a first-aid course, fire prevention and reaction training and universal precautions training. These training courses shall be completed no less than annually.

d. Within the first six months of commencement of direct service provision, employees shall complete training required by 441—subparagraph 78.54(3)*"a"*(6).

e. Within 12 months of the commencement of direct service provision, employees shall complete a department-approved, nationally recognized certified brain injury specialist training.

f. The organization shall have in place an outcome management system which measures the efficiency and effectiveness of service provision, including members' preadmission location of service, length of stay, discharge location, reason for discharge, member and stakeholder satisfaction, and access to services.

g. The organization shall have in place a systematic, organization-wide, planned approach to designing, measuring, evaluating, and improving the level of its performance. The organization shall be required to:

(1) Measure and analyze organizational activities and services quarterly.

(2) Conduct satisfaction surveys with members, family members, employees and stakeholders, and share the information with the public.

(3) Conduct an internal review of member service records at regular intervals.

(4) Track major and minor incident data according to subrule 77.37(8) and unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof; and analyze the data to identify trends annually to ensure the health and safety of members served by the organization.

(5) Continuously identify areas in need of improvement.

(6) Develop a plan to address the identified areas in need of improvement.

(7) Implement the plan, document the results, and report to the governing body annually.

h. The organization shall have in place written policies and procedures and a personnel training program for the identification and reporting of child and dependent adult abuse to the department pursuant to 441—Chapters 175 and 176.

i. The organization's governing body shall have an active role in the administration of the organization.

j. The organization's governing body shall receive and use input from local community stakeholders, members participating in services, and employees and shall provide oversight that ensures the provision of high-quality supports and services to members.

k. The organization shall implement the following outcome-based standards for rights and dignity:

(1) Members are valued.

(2) The member and the member's treatment team mutually develop an individualized service plan (ISP) that takes into account the member's individual strengths, barriers and interests. The service plan shall include goals which are based on the member's need for services and shall address the neurobehavioral challenges and environmental needs as identified in the member's individual standardized comprehensive functional neurobehavioral assessment.

(3) The member and the member's treatment team evaluate the member's progress towards treatment goals regularly and no less than quarterly. Treatment plans are reviewed regularly, but not less than quarterly, and are revised as the member's status or needs change to reflect the member's progress and response to treatment.

(4) The member and the member's legal representative have the right to file grievances regarding the provider's implementation of the organizational standards, or its employee's or contractual person's action which affects the member. The provider shall provide to members the policies and procedures for member grievances and appeals at the commencement of services and annually thereafter.

(5) When a member requires any restrictive interventions, the interventions will be implemented in accordance with 481—subrule 63.23(4), rule 481—63.33(135C), and rule 481—63.37(135C). When a member has a guardian or legal representative, the guardian or legal representative shall provide informed consent to treat and consent for any restrictive interventions that may be required to protect the health or safety of the member. Restrictive interventions include but are not limited to:

1. Restraint, including chemical restraint, manual restraint or mechanical restraint;
2. Alarms added to a member's natural environment including doors, windows, refrigerators, cabinets, and other home appliances and fixtures;
3. Exclusionary time out;
4. Intensive staffing for control of behavior;
5. Limited access or contingency access to preferred items or activities naturally available in the member's environment;
6. Reprimand;
7. Response cost; and
8. Use of psychotropic medications to control the occurrence of an unwanted behavior.

(6) Members receive individualized services.

(7) Members or their legal representatives provide written consent regarding which personal information is shared and with whom.

(8) Members receive assistance with accessing financial management services as needed.

(9) Members receive assistance with obtaining preventive, appropriate and timely medical and dental care.

(10) The member's living environment is reasonably safe and located in the community.

(11) The member's desire for intimacy is respected and supported.

[**ARC 2341C**, IAB 1/6/16, effective 2/10/16]

[Filed 3/11/70, amended 6/21/73, 2/13/75, 3/21/75]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 2/8/78, Notice 12/28/78—published 3/8/78, effective 4/12/78]
[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
[Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 1/1/89]
[Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 4/13/90, Notice 11/29/90—published 5/2/90, effective 8/1/90]
[Filed 7/13/90, Notice 5/16/90—published 8/8/90, effective 10/1/90]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notice 11/14/90—published 2/6/91, effective 4/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]

[Filed 6/14/91, Notice 5/1/91—published 7/10/91, effective 9/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92]
[Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
[Filed emergency 12/16/93 after Notice 10/27/93—published 1/5/94, effective 1/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed emergency 2/10/94 after Notice 1/5/94—published 3/2/94, effective 3/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/5/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
[Filed 11/16/95, Notices 8/2/95, 9/13/95, 9/27/95—published 12/6/95, effective 2/1/96]
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
[Filed 10/9/96, Notice 8/14/96—published 11/6/96, effective 1/1/97]
[Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]
[Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed emergency 9/13/99—published 10/6/99, effective 10/1/99]
[Filed 11/10/99, Notice 10/6/99—published 12/1/99, effective 2/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
[Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
[Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02][1]
[Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02][1]
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
[Filed 1/9/02, Notice 11/14/01—published 2/6/02, effective 4/1/02]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/15/02][2]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03][1]

[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
[Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
[Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
[Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
[Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]
[Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
[Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]
[Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
[Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]
[Filed ARC 7936B (Notice ARC 7653B, IAB 3/25/09), IAB 7/1/09, effective 9/1/09]
[Filed ARC 9314B (Notice ARC 9112B, IAB 10/6/10), IAB 12/29/10, effective 3/1/11]
[Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
[Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
[Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective 8/1/11]
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]
[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0485C (Notice ARC 0259C, IAB 8/8/12), IAB 12/12/12, effective 2/1/13]
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
[Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
[Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1149C (Notice ARC 0911C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1445C (Notice ARC 1366C, IAB 3/5/14), IAB 4/30/14, effective 7/1/14]
[Filed ARC 1638C (Notice ARC 1553C, IAB 7/23/14), IAB 10/1/14, effective 11/5/14]
[Filed ARC 1698C (Notice ARC 1618C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
[Filed ARC 1807C (Notice ARC 1707C, IAB 10/29/14), IAB 1/7/15, effective 3/1/15]
[Filed ARC 2165C (Notice ARC 2061C, IAB 7/22/15), IAB 9/30/15, effective 12/1/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]

[Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
[Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
[Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]

[1] Two ARCs

[2] December 15, 2002, effective date of 77.37(14)*"e"*(2) and 77.39(13)*"e"* delayed 70 days by the Administrative Rules Review Committee at its meeting held December 10, 2002; at its meeting held February 21, 2003, the Committee delayed the effective date until adjournment of the 2003 Session of the General Assembly.

CHAPTER 78
AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL SERVICES

[Prior to 7/1/83, Social Services[770] Ch 78]
[Prior to 2/11/87, Human Services[498]]

441—78.1(249A) Physicians' services. Payment will be approved for all medically necessary services and supplies provided by the physician including services rendered in the physician's office or clinic, the home, in a hospital, nursing home or elsewhere.

Payment shall be made for all services rendered by a doctor of medicine or osteopathy within the scope of this practice and the limitations of state law subject to the following limitations and exclusions:

78.1(1) Payment will not be made for:

a. Drugs dispensed by a physician or other legally qualified practitioner (dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse practitioner) unless it is established that there is no licensed retail pharmacy in the community in which the legally qualified practitioner's office is maintained. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health.

b. Routine physical examinations. Rescinded IAB 8/1/07, effective 8/1/07.

c. Treatment of certain foot conditions as specified in 78.5(2)*"a," "b,"* and *"c."*

d. Acupuncture treatments.

e. Rescinded 9/6/78.

f. Unproven or experimental medical and surgical procedures. The criteria in effect in the Medicare program shall be utilized in determining when a given procedure is unproven or experimental in nature.

g. Charges for surgical procedures on the "Outpatient/Same Day Surgery List" produced by the IME medical services unit or associated inpatient care charges when the procedure is performed in a hospital on an inpatient basis unless the physician has secured approval from the hospital's utilization review department prior to the patient's admittance to the hospital. Approval shall be granted only when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The "Outpatient/Same Day Surgery List" shall be published by the department in the provider manuals for hospitals and physicians. The "Outpatient/Same Day Surgery List" shall be developed by the IME medical services unit and shall include procedures which can safely and effectively be performed in a doctor's office or on an outpatient basis in a hospital. The IME medical services unit may add, delete, or modify entries on the "Outpatient/Same Day Surgery List."

h. Elective, non-medically necessary cesarean section (C-section) deliveries.

78.1(2) Drugs and supplies may be covered when prescribed by a legally qualified practitioner as provided in this rule.

a. Drugs are covered as provided by rule 441—78.2(249A).

b. Medical supplies are payable when ordered by a legally qualified practitioner for a specific rather than incidental use, subject to the conditions specified in rule 441—78.10(249A). When a member is receiving care in a nursing facility or residential care facility, payment will be approved only for the following supplies when prescribed by a legally qualified practitioner:

(1) Colostomy and ileostomy appliances.

(2) Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

(3) Disposable irrigation trays or sets.

(4) Disposable catheterization trays or sets.

(5) Indwelling Foley catheter.

(6) Disposable saline enemas.

(7) Diabetic supplies including needles and syringes, blood glucose test strips, and diabetic urine test supplies.

c. Prescription records are required for all drugs as specified in Iowa Code sections 124.308, 155A.27 and 155A.29. For the purposes of the medical assistance program, prescriptions for medical supplies are required and shall be subject to the same provisions.

d. Rescinded IAB 1/30/08, effective 4/1/08.

e. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a physician must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

f. Nonprescription drugs. Rescinded IAB 1/30/08, effective 4/1/08.

78.1(3) Payment will be approved for injections provided they are reasonable, necessary, and related to the diagnosis and treatment of an illness or injury. When billing for an injection, the legally qualified practitioner must specify the brand name of the drug and the manufacturer, the strength of the drug, the amount administered, and the charge of each injection. When the strength and dosage of the drug is not included, payment will be made based on the customary dosage. The following exclusions are applicable.

a. Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

b. Payment will not be approved for an injection when administered for a reason other than the treatment of a particular condition, illness, or injury. When injecting an amphetamine or legend vitamin, prior approval must be obtained as specified in 78.1(2)*"a"*(3).

c. Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

d. Allergenic extract materials provided the patient for self-administration shall not exceed a 90-day supply.

e. Payment will not be approved when an injection is determined to fall outside of what is medically reasonable or necessary based on basic standards of medical practice for the required level of care for a particular condition.

f. Payment for vaccines available through the Vaccines for Children (VFC) Program will be approved only if the VFC program stock has been depleted.

g. Payment will not be approved for injections of "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

78.1(4) For the purposes of this program, cosmetic, reconstructive, or plastic surgery is surgery which can be expected primarily to improve physical appearance or which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions. When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions set forth in this subrule. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

a. Coverage under the program is generally not available for cosmetic, reconstructive, or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

(1) Correction of a congenital anomaly; or

(2) Restoration of body form following an accidental injury; or

(3) Revision of disfiguring and extensive scars resulting from neoplastic surgery.

(4) Generally, coverage is limited to those cosmetic, reconstructive, or plastic surgery procedures performed no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration for exception will be given to cases involving children who may require a growth period.

b. Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

(1) Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.

(2) Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.

(3) Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.

(4) Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.

c. When it is determined that a cosmetic, reconstructive, or plastic surgery procedure does not qualify for coverage under the program, all related services and supplies, including any institutional costs, are also excluded.

d. Following is a partial list of cosmetic, reconstructive, or plastic surgery procedures which are not covered under the program. This list is for example purposes only and is not considered all inclusive.

(1) Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

(2) Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.

(3) Augmentation mammoplasties.

(4) Face lifts and other procedures related to the aging process.

(5) Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.

(6) Panniculectomy and body sculpture procedures.

(7) Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.

(8) Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.

(9) Chemical peeling for facial wrinkles.

(10) Dermabrasion of the face.

(11) Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.

(12) Removal of tattoos.

(13) Hair transplants.

(14) Electrolysis.

(15) Sex reassignment.

(16) Penile implant procedures.

(17) Insertion of prosthetic testicles.

e. Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident or treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions. Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. An example of a complication similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne.

78.1(5) The legally qualified practitioner's prescription for medical equipment, appliances, or prosthetic devices shall include the patient's diagnosis and prognosis, the reason the item is required, and an estimate in months of the duration of the need. Payment will be made in accordance with rule 78.10(249A).

78.1(6) Payment will be approved for the examination to establish the need for orthopedic shoes in accordance with rule 441—78.15(249A).

78.1(7) No payment shall be made for the services of a private duty nurse.

78.1(8) Payment for mileage shall be the same as that in effect in part B of Medicare.

78.1(9) Payment will be approved for visits to patients in nursing facilities subject to the following conditions:

a. Payment will be approved for only one visit to the same patient in a calendar month. Payment for further visits will be made only when the need for the visits is adequately documented by the physician.

b. When only one patient is seen in a single visit the allowance shall be based on a follow-up home visit. When more than one patient is seen in a single visit, payment shall be based on a follow-up office visit. In the absence of information on the claim, the carrier will assume that more than one patient was seen, and payment approved on that basis.

c. Payment will be approved for mileage in connection with nursing home visits when:

(1) It is necessary for the physician to travel outside the home community, and

(2) There are not physicians in the community in which the nursing home is located.

d. Payment will be approved for tasks related to a resident receiving nursing facility care which are performed by a physician's employee who is a nurse practitioner, clinical nurse specialist, or physician assistant as specified in 441—paragraph 81.13(13)*"e."* On-site supervision of the physician is not required for these services.

78.1(10) Payment will be approved in independent laboratory when it has been certified as eligible to participate in Medicare.

78.1(11) Rescinded, effective 8/1/87.

78.1(12) Payment will be made on the same basis as in Medicare for services associated with treatment of chronic renal disease including physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis. Payment will be made for deductibles and coinsurance for those persons eligible for Medicare.

78.1(13) Payment will be made to the physician for services rendered by auxiliary personnel employed by the physician and working under the direct personal supervision of the physician, when such services are performed incident to the physician's professional service.

a. Auxiliary personnel are nurses, physician's assistants, psychologists, social workers, audiologists, occupational therapists and physical therapists.

b. An auxiliary person is considered to be an employee of the physician if the physician:

(1) Is able to control the manner in which the work is performed, i.e., is able to control when, where and how the work is done. This control need not be actually exercised by the physician.

(2) Sets work standards.

(3) Establishes job description.

(4) Withholds taxes from the wages of the auxiliary personnel.

c. Direct personal supervision in the office setting means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Direct personal supervision outside the office setting, such as the member's home, hospital, emergency room, or nursing facility, means the physician must be present in the same room as the auxiliary person.

Advanced registered nurse practitioners certified under board of nursing rules 655—Chapter 7 performing services within their scope of practice are exempt from the direct personal supervision requirement for the purpose of reimbursement to the employing physicians. In these exempted circumstances, the employing physicians must still provide general supervision and be available to provide immediate needed assistance by telephone. Advanced registered nurse practitioners who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

A physician assistant licensed under board of physician assistants' professional licensure rules in 645—Chapter 325 is exempt from the direct personal supervision requirement but the physician must still provide general supervision and be available to provide immediate needed assistance by telephone. Physician assistants who prescribe drugs and medical devices are subject to the guidelines in effect for physicians as specified in rule 441—78.1(249A).

d. Services incident to the professional services of the physician means the service provided by the auxiliary person must be related to the physician's professional service to the member. If the physician

has not or will not perform a personal professional service to the member, the clinical records must document that the physician assigned treatment of the member to the auxiliary person.

78.1(14) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a physician for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.1(15) The certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance record is sufficient for the original certification.

78.1(16) No payment will be made for sterilization of an individual under the age of 21 or who is mentally incompetent or institutionalized. Payment will be made for sterilization performed on an individual who is aged 21 or older at the time the informed consent is obtained and who is mentally competent and not institutionalized when all the conditions in this subrule are met.

a. The following definitions are pertinent to this subrule:

(1) Sterilization means any medical procedure, treatment, or operation performed for the purpose of rendering an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment of an operation on the genital urinary tract. Mental illness or retardation is not considered an illness or injury.

(2) Hysterectomy means a medical procedure or operation to remove the uterus.

(3) Mentally incompetent individual means a person who has been declared mentally incompetent by a federal, state or local court of jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

(4) Institutionalized individual means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or an individual who is confined under a voluntary commitment in a mental hospital or other facility for the care and treatment of mental illness.

b. The sterilization shall be performed as the result of a voluntary request for the services made by the person on whom the sterilization is performed. The person's consent for sterilization shall be documented on:

(1) Form 470-0835 or 470-0835(S), Consent Form, or

(2) An official sterilization consent form from another state's Medicaid program that contains all information found on the Iowa form and complies with all applicable federal regulations.

c. The person shall be advised prior to the receipt of consent that no benefits provided under the medical assistance program or other programs administered by the department may be withdrawn or withheld by reason of a decision not to be sterilized.

d. The person shall be informed that the consent can be withheld or withdrawn any time prior to the sterilization without prejudicing future care and without loss of other project or program benefits.

e. The person shall be given a complete explanation of the sterilization. The explanation shall include:

(1) A description of available alternative methods and the effect and impact of the proposed sterilization including the fact that it must be considered to be an irreversible procedure.

(2) A thorough description of the specific sterilization procedure to be performed and benefits expected.

(3) A description of the attendant discomforts and risks including the type and possible effects of any anesthetic to be used.

(4) An offer to answer any inquiries the person to be sterilized may have concerning the procedure to be performed. The individual shall be provided a copy of the informed consent form in addition to the oral presentation.

f. At least 30 days and not more than 180 days shall have elapsed following the signing of the informed consent except in the case of premature delivery or emergency abdominal surgery which occurs

not less than 72 hours after the informed consent was signed. The informed consent shall have been signed at least 30 days before the expected delivery date for premature deliveries.

g. The information in paragraphs *"b"* through *"f"* shall be effectively presented to a blind, deaf, or otherwise handicapped individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

h. The consent form described in paragraph 78.1(16)*"b"* shall be attached to the claim for payment and shall be signed by:

(1) The person to be sterilized,

(2) The interpreter, when one was necessary,

(3) The physician, and

(4) The person who provided the required information.

i. Informed consent shall not be obtained while the individual to be sterilized is:

(1) In labor or childbirth, or

(2) Seeking to obtain or obtaining an abortion, or

(3) Under the influence of alcohol or other substance that affects the individual's state of awareness.

j. Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization and only when one or more of the following conditions is met:

(1) The individual or representative has signed an acknowledgment that she has been informed orally and in writing from the person authorized to perform the hysterectomy that the hysterectomy will make the individual permanently incapable of reproducing, or

(2) The individual was already sterile before the hysterectomy, the physician has certified in writing that the individual was already sterile at the time of the hysterectomy and has stated the cause of the sterility, or

(3) The hysterectomy was performed as a result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible and the physician includes a description of the nature of the emergency.

78.1(17) Abortions. Payment for an abortion or related service is made when Form 470-0836 is completed for the applicable circumstances and is attached to each claim for services. Payment for an abortion is made under one of the following circumstances:

a. The physician certifies that the pregnant woman's life would be endangered if the fetus were carried to term.

b. The physician certifies that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and the physician states the medical indication for determining the fetal condition.

c. The pregnancy was the result of rape reported to a law enforcement agency or public or private health agency which may include a family physician within 45 days of the date of occurrence of the incident. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of the rape.

d. The pregnancy was the result of incest reported to a law enforcement agency or public or private health agency including a family physician no later than 150 days after the date of occurrence. The report shall include the name, address, and signature of the person making the report. Form 470-0836 shall be signed by the person receiving the report of incest.

78.1(18) Payment and procedure for obtaining eyeglasses, contact lenses, and visual aids, shall be the same as described in 441—78.6(249A). (Cross reference 78.28(3))

78.1(19) Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the IME medical services unit and the department. If not so approved by the IME medical services unit, payment will not be made under the

program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

78.1(20) Transplants.

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

(1) Kidney, cornea, skin, and bone transplants.

(2) Allogeneic stem cell transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome, follicular lymphoma, Fanconi anemia, paroxysmal nocturnal hemoglobinuria, pure red cell aplasia, amegakaryocytosis/congenital thrombocytopenia, beta thalassemia major, sickle cell disease, Hurler's syndrome (mucopolysaccharidosis type 1 [MPS-1]), adrenoleukodystrophy, metachromatic leukodystrophy, refractory anemia, agnogenic myeloid metaplasia (myelofibrosis), familial erythrophagocytic lymphohistiocytosis and other histiocytic disorders, acute myelofibrosis, Diamond-Blackfan anemia, epidermolysis bullosa, or the following types of leukemia: acute myelocytic leukemia, chronic myelogenous leukemia, juvenile myelomonocytic leukemia, chronic myelomonocytic leukemia, acute myelogenous leukemia, and acute lymphocytic leukemia.

(3) Autologous stem cell transplants for treatment of the following conditions: acute leukemia; chronic lymphocytic leukemia; plasma cell leukemia; non-Hodgkin's lymphomas; Hodgkin's lymphoma; relapsed Hodgkin's lymphoma; lymphomas presenting poor prognostic features; follicular lymphoma; neuroblastoma; medulloblastoma; advanced Hodgkin's disease; primitive neuroendocrine tumor (PNET); atypical/rhabdoid tumor (ATRT); Wilms' tumor; Ewing's sarcoma; metastatic germ cell tumor; or multiple myeloma.

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

Liver transplants require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)*"f"*)

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

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

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

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

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

1. Simultaneous pancreas-kidney transplants and pancreas after kidney transplants are covered.
2. Pancreas transplants alone are covered for persons exhibiting any of the following:

- A history of frequent, acute, and severe metabolic complications (e.g., hypoglycemia, hyperglycemia, or ketoacidosis) requiring medical attention.
- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.
- Consistent failure of insulin-based management to prevent acute complications.

The pancreas transplants listed under this subparagraph require preprocedure review by the IME medical services unit. (Cross references 78.1(19) and 78.28(1)*"f"*)

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

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

b. Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

c. All transplants must be medically necessary and meet other general requirements of this chapter for physician and hospital services.

d. Payment will not be made for any transplant not specifically listed in paragraph *"a."*

78.1(21) Utilization review. Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. For the purposes of utilization review, the term "physician" does not include a psychiatrist. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.1(22) Risk assessment. Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. Enhanced services include health education, social services, nutrition education, and a postpartum home visit. Additional reimbursement shall be provided for obstetrical services related to a high-risk pregnancy. (See description of enhanced services at subrule 78.25(3).)

78.1(23) EPSDT care coordination. Rescinded IAB 12/3/08, effective 2/1/09.

78.1(24) Topical fluoride varnish. Payment shall be made for application of an FDA-approved topical fluoride varnish, as defined by the current version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association, for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians or other appropriately licensed practitioners under the supervision of or in collaboration with a physician and who are acting within the scope of their practice, licensure, and other applicable state law, subject to the following provisions and limitations:

a. Application of topical fluoride varnish must be provided in conjunction with an early and periodic screening, diagnosis, and treatment (EPSDT) examination which includes a limited oral screening.

b. Separate payment shall be available only for application of topical fluoride varnish, which shall be at the same rate of reimbursement paid to dentists for providing this service. Separate payment for the limited oral screening shall not be available, as this service is already part of and paid under the EPSDT screening examination.

c. Parents, legal guardians, or other authorized caregivers of children receiving application of topical fluoride varnish as part of an EPSDT screening examination shall be informed by the physician or auxiliary staff employed by and under the physician's supervision that this application is not a substitute for comprehensive dental care.

d. Physicians rendering the services under this subrule shall make every reasonable effort to refer or facilitate referral of these children for comprehensive dental care rendered by a dental professional.

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

[**ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0846C**, IAB 7/24/13, effective 7/1/13; **ARC 1052C**, IAB 10/2/13, effective 11/6/13; **ARC 1297C**, IAB 2/5/14, effective 4/1/14; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.2(249A) Prescribed outpatient drugs. Payment will be made for "covered outpatient drugs" as defined in 42 U.S.C. Section 1396r-8(k)(2)-(4) subject to the conditions and limitations specified in this rule.

78.2(1) *Qualified prescriber.* All drugs are covered only if prescribed by a legally qualified practitioner (physician, dentist, podiatrist, optometrist, physician assistant, or advanced registered nurse

practitioner). Pursuant to Public Law 111-148, Section 6401, any practitioner prescribing drugs must be enrolled with the Iowa Medicaid enterprise in order for such prescribed drugs to be eligible for payment.

78.2(2) *Prescription required.* As a condition of payment for all drugs, including "nonprescription" or "over-the-counter" drugs that may otherwise be dispensed without a prescription, a prescription shall be transmitted as specified in Iowa Code sections 124.308 and 155A.27, subject to the provisions of Iowa Code section 155A.29 regarding refills. All prescriptions shall be available for audit by the department.

78.2(3) *Qualified source.* All drugs are covered only if marketed by manufacturers that have signed a Medicaid rebate agreement with the Secretary of Health and Human Services in accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990).

78.2(4) *Prescription drugs.* Drugs that may be dispensed only upon a prescription are covered subject to the following limitations.

a. Prior authorization is required as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A as amended by 2010 Iowa Acts, Senate File 2088, section 347.

(1) For any drug requiring prior authorization, reimbursement will be made for a 72-hour or three-day supply dispensed in an emergency when a prior authorization request cannot be submitted.

(2) Unless the manufacturer or labeler of a mental health prescription drug that has a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class enters into a contract to provide the state with a supplemental rebate, the drug may be placed on the preferred drug list as nonpreferred, with prior authorization required. However, prior authorization shall not be required for such a drug for a member whose regimen on the drug was established before January 1, 2011, as verified by documented pharmacy claims.

(3) For mental health prescription drugs requiring prior authorization that have a significant variation in therapeutic or side effect profile from other drugs in the same therapeutic class, reimbursement will be made for up to a seven-day supply pending prior authorization. A request for prior authorization shall be deemed approved if the prescriber:

1. Has on file with the department current contact information, including a current fax number, and a signed Form 470-4914, Fax Confidentiality Certificate, and

2. Does not receive a notice of approval or disapproval within 48 hours of a request for prior authorization.

b. Payment is not made for:

(1) Drugs whose prescribed use is not for a medically accepted indication as defined by Section 1927(k)(6) of the Social Security Act.

(2) Drugs used for anorexia, weight gain, or weight loss.

(3) Drugs used for cosmetic purposes or hair growth.

(4) Rescinded IAB 2/8/12, effective 3/14/12.

(5) Otherwise covered outpatient drugs if the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

(6) Drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (within the meaning of Section 310.6(b)(1) of Title 21 of the Code of Federal Regulations (drugs identified through the Drug Efficacy Study Implementation (DESI) review)).

(7) "Covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for any "Part D eligible individual" as defined by 42 U.S.C. Section 1395w-101(a)(3)(A), including a member who is not enrolled in a Medicare Part D plan.

(8) Drugs prescribed for fertility purposes, except when prescribed for a medically accepted indication other than infertility, as defined in subparagraph (1).

(9) Drugs used for the treatment of sexual or erectile dysfunction, except when used to treat a condition other than sexual or erectile dysfunction for which the drug has been approved by the U.S. Food and Drug Administration.

(10) Prescription drugs for which the prescription was executed in written (and nonelectronic) form unless the prescription was executed on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

(11) Drugs used for symptomatic relief of cough and colds, except for nonprescription drugs listed at subrule 78.2(5).

(12) Investigational drugs, including drugs that are the subject of an investigational new drug (IND) application allowed to proceed by the U.S. Food and Drug Administration (FDA) but that do not meet the definition of a covered outpatient drug in 42 U.S.C. 1396r-8(k)(2)-(4).

78.2(5) *Nonprescription drugs.*

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

Acetaminophen tablets 325 mg, 500 mg
Acetaminophen elixir 160 mg/5 ml
Acetaminophen solution 100 mg/ml
Acetaminophen suppositories 120 mg
Artificial tears ophthalmic solution
Artificial tears ophthalmic ointment
Aspirin tablets 325 mg, 650 mg, 81 mg (chewable)
Aspirin tablets, enteric coated 325 mg, 650 mg, 81 mg
Aspirin tablets, buffered 325 mg
Bacitracin ointment 500 units/gm
Benzoyl peroxide 5%, gel, lotion
Benzoyl peroxide 10%, gel, lotion
Calcium carbonate chewable tablets 500 mg, 750 mg, 1000 mg, 1250 mg
Calcium carbonate suspension 1250 mg/5 ml
Calcium carbonate tablets 600 mg
Calcium carbonate-vitamin D tablets 500 mg-200 units
Calcium carbonate-vitamin D tablets 600 mg-200 units
Calcium citrate tablets 950 mg (200 mg elemental calcium)
Calcium gluconate tablets 650 mg
Calcium lactate tablets 650 mg
Cetirizine hydrochloride liquid 1 mg/ml
Cetirizine hydrochloride tablets 5 mg
Cetirizine hydrochloride tablets 10 mg
Chlorpheniramine maleate tablets 4 mg
Clotrimazole vaginal cream 1%
Diphenhydramine hydrochloride capsules 25 mg
Diphenhydramine hydrochloride elixir, liquid, and syrup 12.5 mg/5 ml
Epinephrine racemic solution 2.25%
Ferrous sulfate tablets 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine syrup 5 mg/5 ml
Loratadine tablets 10 mg
Magnesium hydroxide suspension 400 mg/5 ml

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

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

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

78.2(6) *Quantity prescribed and dispensed.*

a. When it is not therapeutically contraindicated, the legally qualified practitioner shall prescribe a quantity of prescription medication sufficient for up to a 31-day supply. Oral contraceptives may be prescribed in 90-day quantities.

b. Oral solid forms of covered nonprescription items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription or the currently available consumer package size except when dispensed via a unit-dose system.

78.2(7) *Lowest cost item.* The pharmacist shall dispense the lowest cost item in stock that meets the requirements of the practitioner as shown on the prescription.

78.2(8) *Consultation.* In accordance with Public Law 101-508 (Omnibus Budget Reconciliation Act of 1990), a pharmacist shall offer to discuss information regarding the use of the medication with each Medicaid member or the caregiver of a member presenting a prescription. The consultation is not required if the person refuses the consultation. Standards for the content of the consultation shall be found in rules of the Iowa board of pharmacy.

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

[**ARC 8097B**, IAB 9/9/09, effective 11/1/09; **ARC 9175B**, IAB 11/3/10, effective 1/1/11; **ARC 9699B**, IAB 9/7/11, effective 9/1/11; **ARC 9834B**, IAB 11/2/11, effective 11/1/11; **ARC 9882B**, IAB 11/30/11, effective 1/4/12; **ARC 9981B**, IAB 2/8/12, effective 3/14/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0580C**, IAB 2/6/13, effective 4/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2930C**, IAB 2/1/17, effective 4/1/17]

441—78.3(249A) Inpatient hospital services. Payment for inpatient hospital admission is approved when it meets the criteria for inpatient hospital care as determined by the Iowa Medicaid enterprise. All cases are subject to random retrospective review and may be subject to a more intensive retrospective review if abuse is suspected. In addition, transfers, outliers, and readmissions within 31 days are subject to random review. Selected admissions and procedures are subject to a 100 percent review before the services are rendered. Medicaid payment for inpatient hospital admissions and continued stays are approved when the admissions and continued stays are determined to meet the criteria for inpatient hospital care. (Cross reference 78.28(5)) The criteria are available from the IME Medical Services Unit, 100 Army Post Road, Des Moines, Iowa 50315, or in local hospital utilization review offices. No payment will be made for waiver days.

See rule 441—78.31(249A) for policies regarding payment of hospital outpatient services.

If the recipient is eligible for inpatient or outpatient hospital care through the Medicare program, payment will be made for deductibles and coinsurance as set out in 441—subrule 79.1(22).

The DRG payment calculations include any special services required by the hospital, including a private room.

78.3(1) Payment for Medicaid-certified physical rehabilitation units will be approved for the day of admission but not the day of discharge or death.

78.3(2) No payment will be approved for private duty nursing.

78.3(3) Certification of inpatient hospital care shall be the same as that in effect in part A of Medicare. The hospital admittance records are sufficient for the original certification.

78.3(4) Services provided for intestinal or gastric bypass surgery for treatment of obesity requires prior approval, which must be obtained by the attending physician before surgery is performed.

78.3(5) Payment will be approved for drugs provided inpatients subject to the same provisions specified in 78.2(1) and 78.2(4)*"b"*(1) to (10) except for 78.2(4)*"b"*(7). The basis of payment for drugs administered to inpatients is through the DRG reimbursement.

a. Payment will be approved for drugs and supplies provided outpatients subject to the same provisions specified in 78.2(1) through 78.2(4) except for 78.2(4)*"b"*(7). The basis of payment for drugs provided outpatients is through a combination of Medicaid-determined fee schedules and ambulatory payment classification, pursuant to 441—subrule 79.1(16).

b. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.3(6) Payment for nursing care provided by a hospital shall be made to those hospitals which have been certified by the department of inspections and appeals as meeting the standards for a nursing facility.

78.3(7) Payment for inpatient hospital tests for purposes of diagnosis and treatment shall be made only when the tests are specifically ordered for the diagnosis and treatment of a particular patient's condition by the attending physician or other licensed practitioner acting within the scope of practice as defined by law, who is responsible for that patient's diagnosis or treatment.

78.3(8) Rescinded IAB 2/6/91, effective 4/1/91.

78.3(9) Payment will be made for sterilizations in accordance with 78.1(16).

78.3(10) Payment will be approved for organ and tissue transplant services, as specified in subrule 78.1(20). Kidney, cornea, skin, bone, allogeneic bone marrow, autologous bone marrow, heart, liver, and lung transplants are covered as specified in subrule 78.1(20). Lung transplants are payable at Medicare-designated lung transplant centers only. Heart and liver transplants are payable when performed at facilities that meet the following criteria:

a. Recipient selection and education.

(1) *Selection.* The transplant center must have written criteria based on medical need for transplantation for final facility selection of recipients. These criteria should include an equitable, consistent and practical protocol for selection of recipients. The criteria must be at least as strict as those specified by Medicare.

(2) *Education.* The transplant center will provide a written plan for recipient education. It shall include educational plans for recipient, family and significant others during all phases of the program. These phases shall include:

Intake.

Preparation and waiting period.

Preadmission.

Hospitalization.

Discharge planning.

Follow-up.

b. Staffing and resource commitment.

(1) *Transplant surgeon.* The transplant center must have on staff a qualified transplant surgeon.

The surgeon must have received at least one year of training at a transplant center approved by the American Society of Transplant Surgeons under the direction of an experienced transplant surgeon and must have had at least two years of experience in all facets of transplant surgery specific to the surgeon's specialty. This experience must include management of recipients' presurgical and postsurgical care and actual experience as a member of a transplant team at the institution. The transplant surgeon will have an understanding of the principles of and demonstrated expertise in the use of immunosuppressive therapy.

The transplant surgeon will be certified by the American Board of Thoracic Surgery or equivalent for heart transplants and the American Board of Surgery or equivalent for liver transplants.

The transplant surgeon will be the defined leader of a stable, established transplant team that has a strong commitment to the transplant program.

(2) *Transplant team.* The transplant team will be clearly defined with leadership and corresponding responsibilities of all team members identified.

The team should consist of:

A surgeon director.

A board-certified internist or pediatrician with training and expertise in organ transplantation medicine and clinical use of immunosuppressive regimens.

The transplant center will assume responsibility for initial training and continuing education of the transplant team and ancillary personnel. The center will maintain records that demonstrate competency in achieving, maintaining and improving skills in the distinct areas of expertise of each of the team members.

(3) *Physicians.* The transplant center will have on staff or available for consultation physicians with the following areas of expertise:

Anesthesiology.

Cardiology.

Dialysis.

Gastroenterology.

Hepatology.

Immunology.

Infectious diseases.

Nephrology.

Neurology.

Pathology.

Pediatrics.

Psychiatry.

Pulmonary medicine.

Radiology.

Rehabilitation medicine.

Liaison with the recipient's permanent physician is established for the purpose of providing continuity and management of the recipient's long-term care.

(4) *Support personnel and resources.* The center must have a commitment of sufficient resources and planning for implementation and operation of the transplant program. Indicators of the commitment will include the following:

Persons with expertise in the following areas available at the transplant center:

Anesthesiology.

Blood bank services.

Cardiology.

Cardiovascular surgery.

Dialysis.

Dietary services.

Gastroenterology.

Infection control.

Laboratory services (pathology, microbiology, immunology, tissue typing, and monitoring of immunosuppressive drugs).

Legal counsel familiar with transplantation laws and regulations.

Nursing service department with staff available who have expertise in the care of transplant recipients, especially in managing immunosuppressed patients and hemodynamic support.

Respiratory therapy.

Pharmaceutical services.

Physical therapy.

Psychiatry.

Psycho-social.

The center will have active cardiovascular, medical, and surgical programs with the ability and willingness to perform diagnostic and evaluative procedures appropriate to transplants on an emergency and ongoing basis.

The center will have designated an adequate number of intensive care and general service beds to support the transplant center.

(5) *Laboratory.* Each transplant center must have direct local 24-hour per day access to histocompatibility testing facilities. These facilities must meet the Standards for Histocompatibility Testing set forth by the Committee on Quality Assurance and Standards of the American Society for Histocompatibility and Immunogenetics (ASHI). As specified by ASHI, the director of the facility shall hold a doctoral degree in biological science, or be a physician, and subsequent to graduation shall have had four years' experience in immunology, two of which were devoted to formal training in human histocompatibility testing, documented to be professionally competent by external measures such as national proficiency testing, participation in national or international workshops or publications in peer-reviewed journals. The laboratory must successfully participate in a regional or national testing program.

c. *Experience and survival rates.*

(1) *Experience.* Centers will be given a minimum volume requirement of 12 heart or 12 liver transplants that should be met within one year. Due to special considerations such as patient case mix or donor availability, an additional one year conditional approval may be given if the minimum volume is not met the first year.

For approval of an extrarenal organ transplant program it is highly desirable that the institution: 1. has available a complete team of surgeons, physicians, and other specialists with specific experience in transplantation of that organ, or 2. has an established approved renal transplant program at that institution and personnel with expertise in the extrarenal organ system itself.

(2) *Survival rates.* The transplant center will achieve a record of acceptable performance consistent with the performance and outcomes at other successful designated transplant centers. The center will collect and maintain recipient and graft survival and complication rates. A level of satisfactory success and safety will be demonstrated with bases for substantial probability of continued performance at an acceptable level.

To encourage a high level of performance, transplant programs must achieve and maintain a minimum one-year patient survival rate of 70 percent for heart transplants and 50 percent for liver transplants.

d. *Organ procurement.* The transplant center will participate in a nationwide organ procurement and typing network.

Detailed plans must exist for organ procurement yielding viable transplantable organs in reasonable numbers, meeting established legal and ethical criteria.

The transplant center must be a member of the National Organ Procurement and Transplant Network.

e. *Maintenance of data, research, review and evaluation.*

(1) *Maintenance of data.* The transplant center will collect and maintain data on the following:

Risk and benefit.

Morbidity and mortality.

Long-term survival.

Quality of life.

Recipient demographic information.

These data should be maintained in the computer at the transplant center monthly.

The transplant center will submit the above data to the United Network of Organ Sharing yearly.

(2) *Research.* The transplant center will have a plan for and a commitment to research.

Ongoing research regarding the transplanted organs is required.

The transplant center will have a program in graduate medical education or have a formal agreement with a teaching institution for affiliation with a graduate medical education program.

(3) *Review and evaluation.* The transplant center will have a plan for ongoing evaluation of the transplantation program.

The transplant center will have a detailed plan for review and evaluation of recipient selection, preoperative, operative, postoperative and long-term management of the recipient.

The transplant center will conduct concurrent ongoing studies to ensure high quality services are provided in the transplantation program.

The transplant center will provide information to members of the transplant team and ancillary staff regarding the findings of the quality assurance studies. This information will be utilized to provide education geared toward interventions to improve staff performance and reduce complications occurring in the transplant process.

The transplant center will maintain records of all quality assurance and peer review activities concerning the transplantation program to document identification of problems or potential problems, intervention, education and follow-up.

f. *Application procedure.* A Medicare-designated heart, liver, or lung transplant facility needs only to submit evidence of this designation to the Iowa Medicaid enterprise provider services unit. The application procedure for other heart and liver facilities is as follows:

(1) An original and two copies of the application must be submitted on 8½ by 11 inch paper, signed by a person authorized to do so. The facility must be a participating hospital under Medicaid and must specify its provider number, and the name and telephone number of a contact person should there be questions regarding the application.

(2) Information and data must be clearly stated, well organized and appropriately indexed to aid in its review against the criteria specified in this rule. Each page must be numbered.

(3) To the extent possible, the application should be organized into five sections corresponding to each of the five major criteria and addressing, in order, each of the subcriteria identified.

(4) The application should be mailed to the Iowa Medicaid enterprise provider services unit.

g. *Review and approval of facilities.* An organized review committee will be established to evaluate performance and survival statistics and make recommendations regarding approval as a designated transplant center based on acceptable performance standards established by the review organization and approved by the Medicaid agency.

There will be established protocol for the systematic evaluation of patient outcome including survival statistics.

Once a facility applies for approval and is approved as a heart or liver transplant facility for Medicaid purposes, it is obliged to report immediately to the department any events or changes which would affect its approved status. Specifically, a facility must report any significant decrease in its experience level or survival rates, the transplantation of patients who do not meet its patient selection criteria, the loss of key members of the transplant team, or any other major changes that could affect the performance of heart or liver transplants at the facility. Changes from the terms of approval may lead to withdrawal of approval for Medicaid coverage of heart or liver transplants performed at the facility.

78.3(11) Payment will be approved for inpatient hospital care rendered a patient in connection with dental treatment only when the mental, physical, or emotional condition of the patient prevents the dentist from providing this necessary care in the office.

78.3(12) Payment will be approved for an assessment fee as specified in 441—paragraphs 79.1(16)*"a"* and *"r"* to determine if a medical emergency exists.

Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given.

The determination of whether a medical emergency exists will be based on the patient's medical condition including presenting symptoms and medical history prior to treatment or evaluation.

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

78.3(14) Payment for patients in acute hospital beds who are determined by the IME medical services unit to require nursing facility level of care shall be made at an amount equal to the sum of the direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1) plus the non-direct care rate component limit for Medicaid nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(1), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by the IME medical services unit that the lower level of care is required or (b) for the days the IME medical services unit determines in an outlier review that the lower level of care was required.

78.3(15) Payment for inpatient hospital charges associated with surgical procedures normally done and billed on an outpatient hospital basis is subject to review by the IME medical services acute retrospective review team. Such reviews are based on random claim samples that are pulled on a monthly basis. If the information on a given inpatient claim included in that sample does not appear to support the appropriateness of inpatient level of care, that claim is sent to the IME medical director for further review. If the medical director approves the inpatient level of care, the claim is paid. However, if the medical director determines that the care provided could have been rendered at a lower level of care, the hospital and attending physician are notified accordingly. If the hospital agrees with the finding that a lower level of care was appropriate, the hospital submits a new claim for the lower level of care. If the hospital disagrees with the lower level of care finding, the hospital can submit additional documentation for further review. The hospital or attending physician or both may appeal any final determination by the IME.

78.3(16) Skilled nursing care in "swing beds."

a. Payment will be made for medically necessary skilled nursing care when provided by a hospital participating in the swing-bed program certified by the department of inspections and appeals and approved by the U.S. Department of Health and Human Services. Payment shall be at an amount equal to the sum of the direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3) and the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16)*"f"*(3),

with the rate component limits being revised July 1, 2001, and every second year thereafter. Swing-bed placement is only intended to be short-term in nature.

b. Any payment for skilled nursing care provided in a hospital with a certified swing-bed program, for either initial admission or continued stay, will require prior authorization, subject to the following requirements:

(1) The hospital has fewer than 100 beds, excluding beds for newborns and intensive care.

(2) The hospital has an existing certification for a swing-bed program, pursuant to paragraph 78.3(16)*"a."*

(3) The member is being admitted for nursing facility or skilled level of care (if the member has Medicare and skilled coverage has been exhausted).

(4) As part of the discharge planning process for a member requiring ongoing skilled nursing care, the hospital must:

1. Complete a level of care (LOC) determination describing a member's LOC needs, using Form 470-5156, Swing Bed Certification.

2. Contact skilled nursing facilities within a 30-mile radius of the hospital regarding available beds to meet the member's LOC needs.

3. Certify that no freestanding skilled nursing facility beds are available for the member within a 30-mile radius of the hospital, which will be able to appropriately meet the member's needs and that home-based care for the member is not available or appropriate.

(5) Swing-bed stays beyond 14 days will only be approved when there is no appropriate freestanding nursing facility bed available within a 30-mile radius and home-based care for the member is not available or appropriate, as documented by the hospital seeking the swing-bed admission. For the purpose of these criteria, an "appropriate" nursing facility bed is a bed in a Medicaid-participating freestanding nursing facility that provides the LOC required for the member's medical condition and corresponding LOC needs.

(6) A Medicaid member who has been in a swing bed beyond 14 days must be discharged to an appropriate nursing facility bed within a 30-mile radius of the swing-bed hospital or to appropriate home-based care within 72 hours of an appropriate nursing facility bed becoming available.

Preadmission screening and resident review (PASRR) rules still apply for members being transferred to a nursing facility.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Preprocedure review is also required for other types of major surgical procedures, such as organ transplants. Criteria are available from the IME medical services unit. (Cross reference 78.28(5))

78.3(19) Rescinded IAB 10/8/97, effective 12/1/97.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 0194C**, IAB 7/11/12, effective 7/1/12; **ARC 0354C**, IAB 10/3/12, effective 12/1/12; **ARC 0844C**, IAB 7/24/13, effective 7/1/13; **ARC 1054C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.4(249A) Dentists. Payment will be made for medical and surgical services furnished by a dentist to the extent these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy. Services must be reasonable, necessary, and cost-effective for the prevention, diagnosis, and treatment of dental disease or injuries or for oral devices necessary for a medical condition. Payment will also be made for the following dental procedures:

78.4(1) *Preventive services.* Payment shall be made for the following preventive services:

a. Oral prophylaxis, including necessary scaling and polishing, is payable only once in a six-month period except for persons who, because of a physical or mental condition, need more frequent care. Documentation supporting the need for oral prophylaxis performed more than once in a six-month period must be maintained.

b. Topical application of fluoride is payable once every 90 days. (This does not include the use of fluoride prophylaxis paste as fluoride treatment.)

c. Pit and fissure sealants are payable for placement on deciduous and permanent posterior teeth only. Reimbursement for sealants is restricted to work performed on members through 18 years of age and on members who have a physical or mental condition that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

d. Space management services are payable in mixed dentition when premature loss of teeth would permit existing teeth to shift and cause a handicapping malocclusion or there is too little dental ridge to accommodate either the number or the size of teeth and significant dental disease will result if the condition is not corrected.

78.4(2) *Diagnostic services.* Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per member per dental practice in a three-year period when the member has not been seen by a dentist in the dental practice during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A full mouth radiograph survey, consisting of a minimum of 14 periapical films and bite-wing films, or a panoramic radiograph with bite-wings is a payable service once in a five-year period, except when medically necessary to evaluate development and to detect anomalies, injuries and diseases. Full mouth radiograph surveys are not payable under the age of six except when medically necessary. A panographic-type radiography with bite-wings is considered the same as a full mouth radiograph survey.

d. Supplemental bitewing films are payable only once in a 12-month period.

e. Single periapical films are payable when necessary.

f. Intraoral radiograph, occlusal.

g. Extraoral radiograph.

h. Posterior-anterior and lateral skull and facial bone radiograph, survey film.

i. Temporomandibular joint radiograph.

j. Cephalometric film.

k. Diagnostic casts are payable only for orthodontic cases or dental implants or when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

l. Cone beam images are payable when medically necessary for situations including, but not limited to, detection of tumors, positioning of severely impacted teeth, supernumerary teeth or dental implants.

78.4(3) *Restorative services.* Payment shall be made for the following restorative services:

a. Treatment of dental caries is payable in those areas which require immediate attention. Restoration of incipient or nonactive carious lesions are not payable. Carious activity may be considered incipient when there is no penetration of the dento-enamel junction as demonstrated in diagnostic radiographs.

b. Amalgam alloy and composite resin-type filling materials are reimbursable only once for the same restoration in a two-year period.

c. Rescinded IAB 5/1/02, effective 7/1/02.

d. Crowns are payable when there is at least a fair prognosis for maintaining the tooth as determined by the Iowa Medicaid enterprise medical services unit and a more conservative procedure would not be serviceable.

(1) Stainless steel crowns are limited to primary and permanent posterior teeth and are covered when coronal loss of tooth structure does not allow restoration with an amalgam or composite restoration. Placement on permanent posterior teeth is allowed only for members who have a mental or physical condition that limits their ability to tolerate the procedure for placement of a different crown.

(2) Aesthetic coated stainless steel crowns and stainless steel crowns with a resin window are limited to primary anterior teeth.

(3) Laboratory-fabricated crowns, other than stainless steel, are limited to permanent teeth and require prior authorization. Approval shall be granted when coronal loss of tooth structure does not allow

restoration with an amalgam or composite restoration or there is evidence of recurring decay surrounding a large existing restoration, a fracture, a broken cusp(s), or an endodontic treatment.

(4) Crowns with noble or high noble metals require prior authorization. Approval shall be granted for members who meet the criteria for a laboratory-fabricated crown, other than stainless steel, and who have a documented allergy to all other restorative materials.

e. Cast post and core, post and composite or post and amalgam in addition to a crown are payable when a tooth is functional and the integrity of the tooth would be jeopardized by no post support.

f. Payment as indicated will be made for the following restoration procedures:

(1) Amalgam or acrylic buildups, including any pins, are considered a core buildup.

(2) One, two, or more restorations on one surface of a tooth shall be paid as a one-surface restoration, i.e., mesial occlusal pit and distal occlusal pit of a maxillary molar or mesial and distal occlusal pits of a lower bicuspid.

(3) Occlusal lingual groove of a maxillary molar that extends from the distal occlusal pit and down the distolingual groove will be paid as a two-surface restoration. This restoration and a mesial occlusal pit restoration on the same tooth will be paid as one, two-surface restoration.

(4) Rescinded IAB 5/1/02, effective 7/1/02.

(5) Two separate one-surface restorations are payable as a two-surface restoration (i.e., an occlusal pit restoration and a buccal pit restoration are a two-surface restoration).

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, and local anesthesia are included in the restorative fee and may not be billed separately.

(7) Pin retention will be paid on a per-tooth basis and in addition to the final restoration.

(8) More than four surfaces on an amalgam restoration will be reimbursed as a "four-surface" amalgam.

(9) An amalgam or composite restoration is not payable following a sedative filling in the same tooth unless the sedative filling was placed more than 30 days previously.

78.4(4) *Periodontal services.* Payment may be made for the following periodontal services:

a. Full-mouth debridement to enable comprehensive periodontal evaluation and diagnosis is payable once every 24 months. This procedure is not payable on the same date of service when other prophylaxis or periodontal services are performed.

b. Periodontal scaling and root planing is payable once every 24 months when prior approval has been received. Prior approval shall be granted per quadrant when radiographs demonstrate subgingival calculus or loss of crestal bone and when the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(2)*"a"*(1))

c. Periodontal surgical procedures which include gingivoplasty, osseous surgery, and osseous allograft are payable services when prior approval has been received. Payment for these surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the member has demonstrated reasonable oral hygiene. Payment is also allowed for members who are unable to demonstrate reasonable oral hygiene due to a physical or mental condition, or who exhibit evidence of gingival hyperplasia, or who have a deep carious lesion that cannot be otherwise accessed for restoration.

d. Tissue grafts. Pedicle soft tissue graft, free soft tissue graft, and subepithelial connective tissue graft are payable services with prior approval. Authorization shall be granted when the amount of tissue loss is causing problems such as continued bone loss, chronic root sensitivity, complete loss of attached tissue, or difficulty maintaining adequate oral hygiene. (Cross reference 78.28(2)*"a"*(2))

e. Periodontal maintenance therapy requires prior authorization. Approval shall be granted for members who have completed periodontal scaling and root planing at least three months prior to the initial periodontal maintenance therapy and the periodontal probe chart shows evidence of pocket depths of 4 mm or greater. (Cross reference 78.28(2)*"a"*(3))

f. Tissue regeneration procedures require prior authorization. Approval shall be granted when radiographs show evidence of recession in relation to the muco-gingival junction and the bone level indicates the tooth has a fair to good long-term prognosis.

g. Localized delivery of antimicrobial agents requires prior authorization. Approval shall be granted when at least one year has elapsed since periodontal scaling and root planing was completed, the member has maintained regular periodontal maintenance, and pocket depths remain at a moderate to severe depth with bleeding on probing. Authorization is limited to once per site every 12 months.

78.4(5) *Endodontic services.* Payment shall be made for the following endodontic services:

a. Root canal treatments on permanent anterior and posterior teeth when there is presence of extensive decay, infection, draining fistulas, severe pain upon chewing or applied pressure, prolonged sensitivity to temperatures, or a discolored tooth indicative of a nonvital tooth.

b. Vital pulpotomies. Cement bases, pulp capping, and insulating liners are considered part of the restoration and may not be billed separately.

c. Surgical endodontic treatment, including an apicoectomy, performed as a separate surgical procedure; an apicoectomy, performed in conjunction with endodontic procedure; an apical curettage; a root resection; or excision of hyperplastic tissue is payable when nonsurgical treatment has been attempted and a reasonable time of approximately one year has elapsed after which failure has been demonstrated. Surgical endodontic procedures may be indicated when:

(1) Conventional root canal treatment cannot be successfully completed because canals cannot be negotiated, debrided or obturated due to calcifications, blockages, broken instruments, severe curvatures, and dilacerated roots.

(2) Correction of problems resulting from conventional treatment including gross underfilling, perforations, and canal blockages with restorative materials. (Cross reference 78.28(2)*"c"*)

d. Endodontic retreatment when prior authorization has been received. Authorization for retreatment of a tooth with previous endodontic treatment shall be granted when the conventional treatment has been completed, a reasonable time has elapsed since the initial treatment, and failure has been demonstrated with a radiograph and narrative history. A reasonable period of time is approximately one year if the treating dentist is the same and may be less if the member must see a different dentist.

78.4(6) *Oral surgery—medically necessary.* Payment shall be made for medically necessary oral surgery services furnished by dentists to the extent that these services may be performed under state law either by doctors of medicine, osteopathy, dental surgery or dental medicine and would be covered if furnished by doctors of medicine or osteopathy, as defined in rule 441—78.1(249A). These services will be reimbursed in a manner consistent with the physician's reimbursement policy. The following surgical procedures are also payable when performed by a dentist:

a. Extractions, both surgical and nonsurgical.

b. Impaction (soft tissue impaction, upper or lower) that requires an incision of overlying soft tissue and the removal of the tooth.

c. Impaction (partial bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and removal of the tooth.

d. Impaction (complete bony impaction, upper or lower) that requires incision of overlying soft tissue, elevation of a flap, removal of bone and section of the tooth for removal.

e. Root recovery (surgical removal of residual root).

f. Oral antral fistula closure (or antral root recovery).

g. Surgical exposure of impacted or unerupted tooth for orthodontic reasons, including ligation when indicated.

h. Surgical exposure of impacted or unerupted tooth to aid eruption.

i. Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.

j. Payment may be made for postoperative care where need is shown to be beyond normal follow-up care or for postoperative care where the original service was performed by another dentist.

78.4(7) *Prosthetic services.* Payment may be made for the following prosthetic services:

a. An immediate denture or a first-time complete denture. Six months' postdelivery care is included in the reimbursement for the denture.

b. A removable partial denture replacing anterior teeth when prior approval has been received. Approval shall be granted when radiographs demonstrate adequate space for replacement of a missing anterior tooth. Six months' postdelivery care is included in the reimbursement for the denture.

c. A removable partial denture replacing posterior teeth including six months' postdelivery care when prior approval has been received. Approval shall be granted when the member has fewer than eight posterior teeth in occlusion, excluding third molars, or the member has a full denture in one arch and a partial denture replacing posterior teeth is required in the opposing arch to balance occlusion. When one removable partial denture brings eight posterior teeth in occlusion, no additional removable partial denture will be approved. Six months' postdelivery care is included in the reimbursement for the denture. (Cross reference 78.28(2)*"b"*(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. Approval shall be granted for members who:

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have an existing bridge that needs replacement due to breakage or extensive, recurrent decay.

High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. (Cross reference 78.28(2)*"b"*(2))

e. A fixed partial denture replacing posterior teeth when prior approval has been received. Approval shall be granted for members who meet the criteria for a removable partial denture and:

(1) Have a physical or mental condition that precludes the use of a removable partial denture, or

(2) Have a full denture in one arch and a partial fixed denture replacing posterior teeth is required in the opposing arch to balance occlusion.

High noble or noble metals will be approved only when the member is allergic to all other restorative materials.

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines and laboratory-processed relines are payable only once per prosthesis every 12 months, beginning 6 months after placement of the denture.

h. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

i. Two repairs per prosthesis in a 12-month period are payable.

j. Adjustments to a complete or removable partial denture are payable when medically necessary after six months' postdelivery care. An adjustment consists of removal of acrylic material or adjustment of teeth to eliminate a sore area or to make the denture fit better. Warming dentures and massaging them for better fit or placing them in a sonic device does not constitute an adjustment.

k. Dental implants and related services when prior authorization has been received. Prior authorization shall be granted when the member is missing significant oral structures due to cancer, traumatic injuries, or developmental defects such as cleft palate and cannot use a conventional denture.

l. Replacement of complete or partial dentures in less than a five-year period requires prior authorization. Approval shall be granted once per denture replacement per arch in a five-year period when the denture has been lost, stolen or broken beyond repair or cannot be adjusted for an adequate fit. Approval shall also be granted for more than one denture replacement per arch within five years for members who have a medical condition that necessitates thorough mastication. Approval will not be granted in less than a five-year period when the reason for replacement is resorption.

m. A complete or partial denture rebase requires prior approval. Approval shall be granted when the acrylic of the denture is cracked or has had numerous repairs and the teeth are in good condition.

n. An oral appliance for obstructive sleep apnea requires prior approval and must be custom-fabricated. Approval shall be granted in accordance with Medicare criteria.

78.4(8) *Orthodontic procedures.* Payment may be made for the following orthodontic procedures:

a. Minor treatment to control harmful habits when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required. (Cross reference 78.28(2)*"c"*)

b. Interceptive orthodontic treatment of the transitional dentition when prior approval has been received. Approval shall be granted when it is cost-effective to lessen the severity of a malformation such that extensive treatment is not required.

c. Comprehensive orthodontic treatment when prior approval has been received. Approval is limited to members under 21 years of age and shall be granted when the member has a severe handicapping malocclusion with a score of 26 or above using the index from the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

78.4(9) *Adjunctive general services.* Payment may be made for the following:

a. Treatment in a hospital. Payment will be approved for dental treatment rendered to a hospitalized member only when the mental, physical, or emotional condition of the member prevents the dentist from providing necessary care in the office.

b. Treatment in a nursing facility. Payment will be approved for dental treatment provided in a nursing facility. When more than one patient is examined during the same nursing home visit, payment will be made by the Medicaid program for only one visit to the nursing home.

c. Office visit. Payment will be approved for an office visit for care of injuries or abnormal conditions of the teeth or supporting structure when treatment procedures or examinations are not billed for that visit.

d. Office calls after hours. Payment will be approved for office calls after office hours in emergency situations. The office call will be paid in addition to treatment procedures.

e. Drugs. Payment will be made for drugs dispensed by a dentist only if there is no licensed retail pharmacy in the community where the dentist's office is located. If eligible to dispense drugs, the dentist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for the writing of prescriptions.

f. Anesthesia. General anesthesia, intravenous sedation, and nonintravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants use of anesthesia. Inhalation of nitrous oxide is payable when the age or physical or mental condition of the member necessitates the use of minimal sedation for dental procedures.

g. Occlusal guard. A removable dental appliance to minimize the effects of bruxism and other occlusal factors requires prior approval. Approval shall be granted when the documentation supports evidence of significant loss of tooth enamel, tooth chipping, headaches or jaw pain.

78.4(10) *Orthodontic services to members 21 years of age or older.* Orthodontic procedures are not covered for members 21 years of age or older.

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

[**ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12; **ARC 0631C**, IAB 3/6/13, effective 5/1/13]

441—78.5(249A) Podiatrists. Payment will be approved only for certain podiatric services.

78.5(1) Payment will be approved for the following orthotic appliances and treatment of nail pathologies:

a. Durable plantar foot orthotic.

b. Plaster impressions for foot orthotic.

c. Molded digital orthotic.

d. Shoe padding when appliances are not practical.

e. Custom molded space shoes for rheumatoid arthritis, congenital defects and deformities, neurotropic, diabetic and ischemic intractable ulcerations and deformities due to injuries.

f. Rams horn (hypertrophic) nails.

g. Onychomycosis (mycotic) nails.

78.5(2) Payment will be made for the same scope of podiatric services available through Part B of Title XVIII (Medicare) except as listed below:

a. Treatment of flatfoot. The term "flatfoot" is defined as a condition in which one or more arches have flattened out.

b. Treatment of subluxations of the foot are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments, or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered.

Reasonable and necessary diagnosis of symptomatic conditions that result from or are associated with partial displacement of foot structures is a covered service. Surgical correction in the subluxated foot structure that is an integral part of the treatment of a foot injury or is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

c. Routine foot care. Routine foot care includes the cutting or removal of corns or callouses, the trimming of nails and other hygienic and preventive maintenance care in the realm of self-care such as cleaning and soaking the feet, the use of skin creams to maintain skin tone of both ambulatory and bedfast patients and any services performed in the absence of localized illness, injury, or symptoms involving the foot.

d. Orthopedic shoes. Payment will not be made for orthopedic shoes or for any device to be worn in or attached to orthopedic shoes or other types of shoes when provided by the podiatrist. Payment will be made to the podiatrist for the examination including tests to establish the need for orthopedic shoes.

78.5(3) Prescriptions are required for drugs and supplies as specified in paragraph 78.1(2)*"c."* Payment shall be made for drugs dispensed by a podiatrist only if there is no licensed retail pharmacy in the community where the podiatrist's office is located. If eligible to dispense drugs, the podiatrist should request a copy of the Prescribed Drugs Manual from the Iowa Medicaid enterprise provider services unit. Payment will not be made for writing prescriptions.

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

441—78.6(249A) Optometrists. Payment will be approved for medically necessary services and supplies provided by the optometrist within the scope of practice of optometry and the limitations of state law, subject to the following limitations and exclusions. Covered optometric services include a professional component and materials.

78.6(1) *Payable professional services.* Payable professional services are:

a. Eye examinations. The coverage of eye examinations depends on the purpose of the examination. Services are covered if the examination is the result of a complaint or symptom of an eye disease or injury. Routine eye examinations are covered once in a 12-month period. These services are rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B. The following levels of service are recognized for optometric examinations:

(1) Intermediate examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program.

(2) Comprehensive examination. A level of optometric or ophthalmological services pertaining to medical examination and evaluation, with initiation or continuation of a diagnostic and treatment program, and a general evaluation of the complete visual system.

b. Medical services. Payment will be approved for medically necessary services and supplies within the scope of practice of the optometrist, including services rendered in the optometrist's office or clinic, the home, a nursing facility, or other appropriate setting. Payment for mileage shall be subject to the same approval and payment criteria as those in effect for Medicare Part B.

c. Auxiliary procedures. The following auxiliary procedures and special tests are payable when performed by an optometrist. Auxiliary procedures and special tests are reimbursed as a separate procedure only when warranted by case history or diagnosis.

(1) Serial tonometry. Single tonometry is part of the intermediate and comprehensive exams and is not payable as a separate procedure as is serial tonometry.

(2) Gonioscopy.

(3) Extended ophthalmoscopy. Routine ophthalmoscopy is part of the intermediate and comprehensive examination and is not payable as a separate procedure. Generally, extended

ophthalmoscopy is considered to be part of the comprehensive examination and, if performed in conjunction with that level of service, is not payable as a separate procedure.

(4) Visual fields. Gross visual field testing is part of general optometric services and is not reported separately.

(5) External photography.

(6) Fundus photography.

(7) Retinal integrity evaluation with a three-mirror lens.

d. Single vision and multifocal spectacle lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When spectacle lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

1. Ordering of corrective lenses.
2. Verification of lenses after fabrication.
3. Adjustment and alignment of completed lens order.

(2) New spectacle lenses are subject to the following limitations:

1. Up to three times for children up to one year of age.
2. Up to four times per year for children one through three years of age.
3. Once every 12 months for children four through seven years of age.
4. Once every 24 months after eight years of age when there is a change in the prescription.

(3) Spectacle lenses made from polycarbonate or equivalent material are allowed for:

1. Children through seven years of age.
2. Members with vision in only one eye.
3. Members with a diagnosis-related illness or disability where regular lenses would pose a safety risk.

e. Rescinded IAB 4/3/02, effective 6/1/02.

f. Frame service.

(1) When a new frame is necessary, the following enumerated professional and technical optometric services are to be provided:

1. Selection and styling.
2. Sizing and measurements.
3. Fitting and adjustment.
4. Readjustment and servicing.

(2) New frames are subject to the following limitations:

1. One frame every six months is allowed for children through three years of age.
2. One frame every 12 months is allowed for children four through seven years of age.
3. When there is a covered lens change and the new lenses cannot be accommodated by the current frame.

(3) Safety frames are allowed for:

1. Children through seven years of age.
2. Members with a diagnosis-related disability or illness where regular frames would pose a safety risk or result in frequent breakage.

g. Rescinded IAB 4/3/02, effective 6/1/02.

h. Repairs or replacement of frames, lenses or component parts. Payment shall be made for service in addition to materials. The service fee shall not exceed the dispensing fee for a replacement frame. Payment shall be made for replacement of glasses when the original glasses have been lost or damaged beyond repair. Replacement of lost or damaged glasses is limited to one pair of frames and two lenses once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Contact lenses. Payment shall be made for documented keratoconus, aphakia, high myopia, anisometropia, trauma, severe ocular surface disease, irregular astigmatism, for treatment of acute or chronic eye disease, or when the member's vision cannot be adequately corrected with spectacle lenses. Contact lenses are subject to the following limitations:

(1) Up to 16 gas permeable contact lenses are allowed for children up to one year of age.

(2) Up to 8 gas permeable contact lenses are allowed every 12 months for children one through three years of age.

(3) Up to 6 gas permeable contact lenses are allowed every 12 months for children four through seven years of age.

(4) Two gas permeable contact lenses are allowed every 24 months for members eight years of age or older.

(5) Soft contact lenses and replacements are allowed when medically necessary.

78.6(2) *Ophthalmic materials.* Ophthalmic materials which are provided in connection with any of the foregoing professional optometric services shall provide adequate vision as determined by the optometrist and meet the following standards:

a. Corrected curve lenses, unless clinically contraindicated.

b. Standard plastic, plastic and metal combination, or metal frames.

c. Prescription standards according to the American National Standards Institute (ANSI) standards and tolerance.

78.6(3) *Reimbursement.* The reimbursement for allowed ophthalmic material is subject to a fee schedule established by the department or to actual laboratory cost as evidenced by an attached invoice. Reimbursement for rose tint is included in the fee for the lenses.

a. Materials payable by fee schedule are:

(1) Spectacle lenses, single vision and multifocal.

(2) Frames.

(3) Case for glasses.

b. Materials payable at actual laboratory cost as evidenced by an attached invoice are:

(1) Contact lenses.

(2) Schroeder shield.

(3) Ptosis crutch.

(4) Safety frames.

(5) Subnormal visual aids.

(6) Photochromatic lenses.

78.6(4) *Prior authorization.* Prior authorization is required for the following:

a. A second lens correction within a 24-month period for members eight years of age and older. Approval shall be given when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process shall be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is at or better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory cost as evidenced by an attached invoice.

d. Approval for photochromatic tint shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Approval for press-on prisms shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

(Cross reference 78.28(3))

78.6(5) *Noncovered services.* Noncovered services include, but are not limited to, the following services:

a. Glasses with cosmetic gradient tint lenses or other eyewear for cosmetic purposes.

b. Glasses for occupational eye safety.

c. A second pair of glasses or spare glasses.

d. Cosmetic surgery and experimental medical and surgical procedures.

e. Sunglasses.

f. Progressive bifocal or trifocal lenses.

78.6(6) *Therapeutically certified optometrists.* Rescinded IAB 9/5/12, effective 11/1/12.

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 0305C**, IAB 9/5/12, effective 11/1/12]

441—78.7(249A) Opticians. Payment will be approved only for certain services and supplies provided by opticians when prescribed by a physician (MD or DO) or an optometrist. Payment and procedure for obtaining services and supplies shall be the same as described in rule 441—78.6(249A). (Cross reference 78.28(3))

78.7(1) to **78.7(3)** Rescinded IAB 4/3/02, effective 6/1/02.

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

441—78.8(249A) Chiropractors. Payment will be made for the same chiropractic procedures payable under Title XVIII of the Social Security Act (Medicare).

78.8(1) *Covered services.* Chiropractic manipulative therapy (CMT) eligible for reimbursement is specifically limited by Medicaid to the manual manipulation (i.e., by use of the hands) of the spine for the purpose of correcting a subluxation demonstrated by X-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae.

78.8(2) *Indications and limitations of coverage.*

a. The subluxation must have resulted in a neuromusculoskeletal condition set forth in the table below for which CMT is appropriate treatment. The symptoms must be directly related to the subluxation that has been diagnosed. The mere statement or diagnosis of "pain" is not sufficient to support the medical necessity of CMT. CMT must have a direct therapeutic relationship to the patient's condition. No other diagnostic or therapeutic service furnished by a chiropractor is covered under the Medicaid program.

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
G44.1	Vascular headache NEC*	G54.0-G54.4	Nerve root and plexus disorders, brachial plexus disorders, lumbosacral plexus disorders, cervical root disorders NEC, thoracic root disorders NEC, lumbosacral root disorders NEC	M48.30-M48.33	Traumatic spondylopathy, site unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region
G44.209	Tension headache, unspecified, not intractable	G54.8	Other nerve root and plexus disorders	M48.35-M48.38	Traumatic spondylopathy, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region
M47.21-M47.28	Other spondylosis with radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G54.9	Nerve root and plexus disorder, unspecified	M50.20-M50.23	Other cervical disc displacement
M47.811-M47.818	Spondylosis without myelopathy or radiculopathy, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	G55	Nerve root and plexus compressions in diseases classified elsewhere	M50.30-M50.33	Other cervical disc degeneration
M47.891-M47.898	Other spondylosis, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region	M43.00-M43.28	Spondylolysis; spondylolisthesis; fusion of spine	M51.24-M51.27	Other thoracic, thoracolumbar and lumbosacral intervertebral disc displacement
M54.2	Cervicalgia	M43.6	Torticollis	M51.34-M51.37	Other thoracic, thoracolumbar and lumbosacral intervertebral disc degeneration
M54.5	Low back pain	M46.00-M46.09	Spinal enthesopathy	M54.30-M54.32	Sciatica
M54.6	Pain in the thoracic spine	M46.41-M46.47	Discitis, unspecified, occipito-atlanto-axial region, cervical region, cervicothoracic region, thoracic region, thoracolumbar region, lumbar region, lumbosacral region	M54.40-M54.42	Lumbago with sciatica
M54.81	Occipital neuralgia	M48.00-M48.08	Spinal stenosis	M96.1	Postlaminectomy syndrome, NEC
M54.89	Other dorsalgia	M48.34	Traumatic spondylopathy, thoracic region		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
M54.9	Dorsalgia, unspecified	M50.10-M50.13	Cervical disc disorder with radiculopathy		
R51	Headache	M50.80-M50.83	Other cervical disc disorders		
		M50.90-M50.93	Cervical disc disorder, unspecified		
		M51.14-M51.17	Intervertebral disc disorders with radiculopathy, thoracic region, thoracolumbar region, lumbar region, lumbosacral region		
		M51.84-M51.87	Other thoracic, thoracolumbar and lumbosacral intervertebral disc disorders		
		M53.0	Cervicocranial syndrome		
		M53.1	Cervicobrachial syndrome		
		M53.2X1-M53.2X9	Spinal instabilities		
		M53.3	Sacrococcygeal disorders NEC		
		M53.80	Other specified dorsopathies, site unspecified		
		M53.84-M53.88	Other specified dorsopathies, thoracic region, thoracolumbar region, lumbar region, lumbosacral region, sacral and sacrococcygeal region		
		M53.9	Dorsopathy, unspecified		
		M54.10-M54.18	Radiculopathy		
		M60.80	Other myositis, unspecified site		
		M60.811, M60.812	Other myositis, shoulder, right, left		
		M60.819	Other myositis, unspecified shoulder		
		M60.821, M60.822	Other myositis, upper arm, right, left		
		M60.829	Other myositis, unspecified upper arm		
		M60.831, M60.832	Other myositis, forearm, right, left		
		M60.839	Other myositis, unspecified forearm		
		M60.841, M60.842	Other myositis, hand, right, left		
		M60.849	Other myositis, unspecified hand		
		M60.851, M60.852	Other myositis, thigh, right, left		
		M60.859	Other myositis, unspecified thigh		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		M60.861, M60.862	Other myositis, lower leg, right, left		
		M60.869	Other myositis, unspecified lower leg		
		M60.871, M60.872	Other myositis, ankle and foot, right, left		
		M60.879	Other myositis, unspecified ankle and foot		
		M60.88, M60.89	Other myositis, other site, multiple sites		
		M60.9	Myositis, unspecified		
		M62.830	Muscle spasm of back		
		M72.9	Fibroblastic disorder, unspecified		
		M79.1	Myalgia		
		M79.2	Neuralgia and neuritis, unspecified		
		M79.7	Fibromyalgia		
		M99.20-M99.23	Subluxation stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.30-M99.33	Osseous stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.40-M99.43	Connective tissue stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.50-M99.53	Intervertebral disc stenosis of neural canal, head region, cervical region, thoracic region, lumbar region		
		M99.60-M99.63	Osseous and subluxation stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		M99.70-M99.73	Connective tissue and disc stenosis of intervertebral foramina, head region, cervical region, thoracic region, lumbar region		
		Q76.2	Congenital spondylolisthesis		
		S13.4XXA, S13.4XXD	Sprain of ligaments of cervical spine, initial encounter, subsequent encounter		

ICD	CATEGORY I	ICD	CATEGORY II	ICD	CATEGORY III
		S13.8XXA, S13.8XXD	Sprain of joints and ligaments of other parts of neck, initial encounter, subsequent encounter		
		S16.1XXA, S16.1XXD	Strain of muscle, fascia and tendon at neck level, initial encounter, subsequent encounter		
		S23.3XXA, S23.3XXD	Sprain of ligaments of thoracic spine, initial encounter, subsequent encounter		
		S23.8XXA, S23.8XXD	Sprain of other specified parts of thorax, initial encounter, subsequent encounter		
		S33.5XXA, S33.5XXD	Sprain of ligaments of lumbar spine, initial encounter, subsequent encounter		
		S33.6XXA, S33.6XXD	Sprain of sacroiliac joint, initial encounter, subsequent encounter		

* NEC means not elsewhere classified.

b. The neuromusculoskeletal conditions listed in the table in paragraph *"a"* generally require short-, moderate-, or long-term CMT. A diagnosis or combination of diagnoses within Category I generally requires short-term CMT of 12 per 12-month period. A diagnosis or combination of diagnoses within Category II generally requires moderate-term CMT of 18 per 12-month period. A diagnosis or combination of diagnoses within Category III generally requires long-term CMT of 24 per 12-month period. For diagnostic combinations between categories, 28 CMTs are generally required per 12-month period. If the CMT utilization guidelines are exceeded, documentation supporting the medical necessity of additional CMT must be submitted with the Medicaid claim form or the claim will be denied for failure to provide information.

c. CMT is not a covered benefit when:

(1) The maximum therapeutic benefit has been achieved for a given condition.

(2) There is not a reasonable expectation that the continuation of CMT would result in improvement of the patient's condition.

(3) The CMT seeks to prevent disease, promote health and prolong and enhance the quality of life.

78.8(3) *Documenting X-ray.* An X-ray must document the primary regions of subluxation being treated by CMT.

a. The documenting X-ray must be taken at a time reasonably proximate to the initiation of CMT. An X-ray is considered to be reasonably proximate if it was taken no more than 12 months prior to or 3 months following the initiation of CMT. X-rays need not be repeated unless there is a new condition and no payment shall be made for subsequent X-rays, absent a new condition, consistent with paragraph *"c"* of this subrule. No X-ray is required for pregnant women and for children aged 18 and under.

b. The X-ray films shall be labeled with the patient's name and date the X-rays were taken and shall be marked right or left. The X-ray shall be made available to the department or its duly authorized representative when requested. A written and dated X-ray report, including interpretation and diagnosis, shall be present in the patient's clinical record.

c. Chiropractors shall be reimbursed for documenting X-rays at the physician fee schedule rate. Payable X-rays shall be limited to those Current Procedural Terminology (CPT) procedure codes that are appropriate to determine the presence of a subluxation of the spine. Criteria used to determine payable X-ray CPT codes may include, but are not limited to, the X-ray CPT codes for which

major commercial payors reimburse chiropractors. The Iowa Medicaid enterprise shall publish in the Chiropractic Services Provider Manual the current list of payable X-ray CPT codes. Consistent with CPT, chiropractors may bill the professional, technical, or professional and technical components for X-rays, as appropriate. Payment for documenting X-rays shall be further limited to one per condition, consistent with the provisions of paragraph *"a"* of this subrule. A claim for a documenting X-ray related to the onset of a new condition is only payable if the X-ray is reasonably proximate to the initiation of CMT for the new condition, as defined in paragraph *"a"* of this subrule. A chiropractor is also authorized to order a documenting X-ray whether or not the chiropractor owns or possesses X-ray equipment in the chiropractor's office. Any X-rays so ordered shall be payable to the X-ray provider, consistent with the provisions in this paragraph.

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

[**ARC 2164C**, IAB 9/30/15, effective 10/1/15]

441—78.9(249A) Home health agencies. Payment shall be approved for medically necessary home health agency services prescribed by a physician in a plan of home health care provided by a Medicare-certified home health agency.

The number of hours of home health agency services shall be reasonable and appropriate to meet an established medical need of the member that cannot be met by a family member, significant other, friend, or neighbor. Services must be medically necessary in the individual case and be related to a diagnosed medical impairment or disability.

The member need not be homebound to be eligible for home health agency services; however, the services provided by a home health agency shall only be covered when provided in the member's residence with the following exception. Private duty nursing and personal care services for persons aged 20 and under as described at 78.9(10)*"a"* may be provided in settings other than the member's residence when medically necessary.

Medicaid members of home health agency services need not first require skilled nursing care to be entitled to home health aide services.

Further limitations related to specific components of home health agency services are noted in subrules 78.9(3) to 78.9(10).

Payment shall be made on an encounter basis. An encounter is defined as separately identifiable hours in which home health agency staff provide continuous service to a member.

Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $15 per month. Dressings, durable medical equipment, and other supplies shall be obtained from a durable medical equipment dealer or pharmacy. Payment of supplies may be made to home health agencies when a durable medical equipment dealer or pharmacy is not available in the member's community.

Payment may be made for restorative and maintenance home health agency services.

Payment may be made for teaching, training, and counseling in the provision of health care services.

Treatment plans for these services shall additionally reflect: to whom the services are to be provided (patient, family member, etc.); prior teaching training, or counseling provided; medical necessity for the rendered service; identification of specific services and goals; date of onset of the teaching, training, or counseling; frequency of services; progress of member in response to treatment; and estimated length of time these services will be needed.

The following are not covered: services provided in the home health agency office, homemaker services, well child care and supervision, and medical equipment rental or purchase.

Services shall be authorized by a physician, evidenced by the physician's signature and date on a plan of treatment.

78.9(1) *Treatment plan.* A plan of treatment shall be completed prior to the start of care and at a minimum reviewed every 60 days thereafter. There must be a face-to-face encounter between a physician, a nurse practitioner, a clinical nurse specialist, a certified nurse-midwife, or a physician assistant and the Medicaid member no more than 90 days before or 30 days after the start of service. The

plan of care shall support the medical necessity and intensity of services to be provided by reflecting the following information:

a. Place of service.

b. Type of service to be rendered and the treatment modalities being used.

c. Frequency of the services.

d. Assistance devices to be used.

e. Date home health services were initiated.

f. Progress of member in response to treatment.

g. Medical supplies to be furnished.

h. Member's medical condition as reflected by the following information, if applicable:

(1) Dates of prior hospitalization.

(2) Dates of prior surgery.

(3) Date last seen by a physician.

(4) Diagnoses and dates of onset of diagnoses for which treatment is being rendered.

(5) Prognosis.

(6) Functional limitations.

(7) Vital signs reading.

(8) Date of last episode of instability.

(9) Date of last episode of acute recurrence of illness or symptoms.

(10) Medications.

i. Discipline of the person providing the service.

j. Certification period (no more than 60 days).

k. Estimated date of discharge from the hospital or home health agency services, if applicable.

l. Physician's signature and date. The plan of care must be signed and dated by the physician before the claim for service is submitted for reimbursement.

78.9(2) *Supervisory visits.* Payment shall be made for supervisory visits two times a month when a registered nurse acting in a supervisory capacity provides supervisory visits of services provided by a home health aide under a home health agency plan of treatment or when services are provided by an in-home health care provider under the department's in-home health-related care program as set forth in 441—Chapter 177.

78.9(3) *Skilled nursing services.* Skilled nursing services are services that when performed by a home health agency require a licensed registered nurse or licensed practical nurse to perform. Situations when a service can be safely performed by the member or other nonskilled person who has received the proper training or instruction or when there is no one else to perform the service are not considered a "skilled nursing service." Skilled nursing services shall be available only on an intermittent basis. Intermittent services for skilled nursing services shall be defined as a medically predictable recurring need requiring a skilled nursing service at least once every 60 days, not to exceed five days per week (except as provided below), with an attempt to have a predictable end. Daily visits (six or seven days per week) that are reasonable and necessary and show an attempt to have a predictable end shall be covered for up to three weeks. Coverage of additional daily visits beyond the initial anticipated time frame may be appropriate for a short period of time, based on the medical necessity of service. Medical documentation shall be submitted justifying the need for continued visits, including the physician's estimate of the length of time that additional visits will be necessary. Daily skilled nursing visits or multiple daily visits for wound care or insulin injections shall be covered when ordered by a physician and included in the plan of care. Other daily skilled nursing visits which are ordered for an indefinite period of time and designated as daily skilled nursing care do not meet the intermittent definition and shall be denied.

Skilled nursing services shall be evaluated based on the complexity of the service and the condition of the patient.

Private duty nursing for persons aged 21 and over is not a covered service. See subrule 78.9(10) for guidelines for private duty nursing for persons aged 20 or under.

78.9(4) *Physical therapy services.* Payment shall be made for physical therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established

by the physician after any needed consultation with the qualified physical therapist, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"b."*

For physical therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(5) *Occupational therapy services.* Payment shall be made for occupational therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"c."*

For occupational therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(6) *Speech therapy services.* Payment shall be made for speech therapy services when the services relate directly to an active written treatment plan, follow a treatment plan established by the physician, are reasonable and necessary to the treatment of the patient's illness or injury, and meet the guidelines defined for restorative, maintenance, or trial therapy as set forth in subrule 78.19(1), paragraphs *"a"* and *"d."*

For speech therapy services, the treatment plan shall additionally reflect goals, modalities of treatment, date of onset of conditions being treated, restorative potential, and progress notes.

78.9(7) *Home health aide services.* Payment shall be made for unskilled services provided by a home health aide if the following conditions are met:

a. The service as well as the frequency and duration are stated in a written plan of treatment established by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

b. The member requires personal care services as determined by a registered nurse or other appropriate therapist. The services shall be given under the supervision of a registered nurse, physical, speech, or occupational therapist and the registered nurse or therapist shall assign the aide who will provide the care.

c. Services shall be provided on an intermittent basis. "Intermittent basis" for home health agency services is defined as services that are usually two to three times a week for two to three hours at a time. Services provided for four to seven days per week, not to exceed 28 hours per week, when ordered by a physician and included in a plan of care shall be allowed as intermittent services. Increased services provided when medically necessary due to unusual circumstances on a short-term basis of two to three weeks may also be allowed as intermittent services when the home health agency documents the need for the excessive time required for home health aide services.

Home health aide daily care may be provided for persons employed or attending school whose disabling conditions require the persons to be assisted with morning and evening activities of daily living in order to support their independent living.

Personal care services include the activities of daily living, e.g., helping the member to bathe, get in and out of bed, care for hair and teeth, exercise, and take medications specifically ordered by the physician, but ordinarily self-administered, and retraining the member in necessary self-help skills.

Certain household services may be performed by the aide in order to prevent or postpone the member's institutionalization when the primary need of the member for home health aide services furnished is for personal care. If household services are incidental and do not substantially increase the time spent by the aide in the home, the entire visit is considered a covered service. Domestic or housekeeping services which are not related to patient care are not a covered service if personal care is not rendered during the visit.

For home health aide services, the treatment plan shall additionally reflect the number of hours per visit and the living arrangement of the member, e.g., lives alone or with family.

78.9(8) *Medical social services.* Rescinded IAB 3/29/17, effective 5/3/17.

78.9(9) *Home health agency care for maternity patients and children.* The intent of home health agency services for maternity patients and children shall be to provide services when the members are unable to receive the care outside of their home and require home health care due to a high-risk factor. Routine prenatal, postpartum, or child health care is a covered service in a physician's office or clinic and, therefore, is not covered by Medicaid when provided by a home health agency.

a. Treatment plans for maternity patients and children shall identify:

(1) The potential risk factors,

(2) The medical factor or symptom which verifies the child is at risk,

(3) The reason the member is unable to obtain care outside of the home,

(4) The medically related task of the home health agency,

(5) The member's diagnosis,

(6) Specific services and goals, and

(7) The medical necessity for the services to be rendered. A single high-risk factor does not provide sufficient documentation of the need for services.

b. The following list of potential high-risk factors may indicate a need for home health services to prenatal maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Previous history of prenatal complications such as fetal death, eclampsia, C-section delivery, psychosis, or diabetes.

(4) Current prenatal problems such as hypertensive disorders of pregnancy, diabetes, cardiac disease, sickle cell anemia, low hemoglobin, mental illness, or drug or alcohol abuse.

(5) Sociocultural or ethnic problems such as language barriers, lack of family support, insufficient dietary practices, history of child abuse or neglect, or single mother.

(6) Preexisting disabilities such as sensory deficits, or mental or physical disabilities.

(7) Second pregnancy in 12 months.

(8) Death of a close family member or significant other within the previous year.

c. The following list of potential high-risk factors may indicate a need for home health services to postpartum maternity patients:

(1) Aged 16 or under.

(2) First pregnancy for a woman aged 35 or over.

(3) Major postpartum complications such as severe hemorrhage, eclampsia, or C-section delivery.

(4) Preexisting mental or physical disabilities such as deaf, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.

(5) Drug or alcohol abuse.

(6) Symptoms of postpartum psychosis.

(7) Special sociocultural or ethnic problems such as lack of job, family problems, single mother, lack of support system, or history of child abuse or neglect.

(8) Demonstrated disturbance in maternal and infant bonding.

(9) Discharge or release from hospital against medical advice before 36 hours postpartum.

(10) Insufficient antepartum care by history.

(11) Multiple births.

(12) Nonhospital delivery.

d. The following list of potential high-risk factors may indicate a need for home health services to infants:

(1) Birth weight of five pounds or under or over ten pounds.

(2) History of severe respiratory distress.

(3) Major congenital anomalies such as neonatal complications which necessitate planning for long-term follow-up such as postsurgical care, poor prognosis, home stimulation activities, or periodic development evaluation.

(4) Disabling birth injuries.

(5) Extended hospitalization and separation from other family members.

(6) Genetic disorders, such as Down's syndrome, and phenylketonuria or other metabolic conditions that may lead to intellectual disability.

(7) Noted parental rejection or indifference toward baby such as never visiting or calling the hospital about the baby's condition during the infant's extended stay.

(8) Family sociocultural or ethnic problems such as low education level or lack of knowledge of child care.

(9) Discharge or release against medical advice before 36 hours of age.

(10) Nutrition or feeding problems.

e. The following list of potential high-risk factors may indicate a need for home health services to preschool or school-age children:

(1) Child or sibling victim of child abuse or neglect.

(2) Intellectual disability or other physical disabilities necessitating long-term follow-up or major readjustments in family lifestyle.

(3) Failure to complete the basic series of immunizations by 18 months, or boosters by 6 years.

(4) Chronic illness such as asthma, cardiac, respiratory or renal disease, diabetes, cystic fibrosis, or muscular dystrophy.

(5) Malignancies such as leukemia or carcinoma.

(6) Severe injuries necessitating treatment or rehabilitation.

(7) Disruption in family or peer relationships.

(8) Suspected developmental delay.

(9) Nutritional deficiencies.

78.9(10) *Private duty nursing or personal care services for persons aged 20 and under.* Payment for private duty nursing or personal care services for persons aged 20 and under shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member. Enhanced payment under the interim fee schedule shall be made available for services to children who are technology dependent, i.e., ventilator dependent or whose medical condition is so unstable as to otherwise require intensive care in a hospital.

Private duty nursing or personal care services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.

2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.

3. Services provided to other persons in the member's household.

4. Services requiring prior authorization that are provided without regard to the prior authorization process.

5. Transportation services.

6. Homework assistance.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include

nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.28(9))

78.9(11) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a home health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 9315B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 3005C**, IAB 3/29/17, effective 5/3/17]

441—78.10(249A) Durable medical equipment (DME), prosthetic devices and medical supplies.

78.10(1) *General payment requirements.* Payment will be made for items of DME, prosthetic devices and medical supplies, subject to the following general requirements and the requirements of subrule 78.10(2), 78.10(3), or 78.10(4), as applicable:

a. DME, prosthetic devices, and medical supplies must be required by the member because of the member's medical condition.

b. The item shall be necessary and reasonable either for the treatment of an illness or injury, or to improve the functioning of a malformed body part. Determination will be made by the Iowa Medicaid enterprise medical services unit.

(1) An item is necessary when it can be expected to make a meaningful contribution to the treatment of a specific illness or injury or to the improvement in function of a malformed body part.

(2) Although an item may be necessary, it must also be a reasonable expenditure for the Medicaid program. The following considerations enter into the determination of reasonableness: Whether the

expense of the item to the program would be clearly disproportionate to the therapeutic benefits which could ordinarily be derived from use of the item; whether the item would be substantially more costly than a medically appropriate and realistically feasible alternative pattern of care; and whether the item serves essentially the same purpose as an item already available to the beneficiary.

c. A physician's (doctor of medicine, osteopathy, or podiatry), physician assistant's, or advanced registered nurse practitioner's prescription is required to establish medical necessity. The prescription shall state the member's name, diagnosis, prognosis, item(s) to be dispensed, quantity, and length of time the item is to be required and shall include the signature of the prescriber and the date of signature.

For items requiring prior authorization, a request shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and sufficient medical documentation to permit an independent conclusion that the requirements for the equipment or device are met and the item is medically necessary and reasonable. A request for prior authorization is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior authorization requirements.

d. Nonmedical items will not be covered. These include but are not limited to:

(1) Physical fitness equipment, e.g., an exercycle, weights.

(2) First-aid or precautionary-type equipment, e.g., preset portable oxygen units.

(3) Self-help devices, e.g., safety grab bars, raised toilet seats.

(4) Training equipment, e.g., speech teaching machines, braille training texts.

(5) Equipment used for environmental control or to enhance the environmental setting, e.g., room heaters, air conditioners, humidifiers, dehumidifiers, and electric air cleaners.

(6) Equipment which basically serves comfort or convenience functions or is primarily for the convenience of a person caring for the member, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the member's medical needs. Payment will not be approved for items that serve duplicate functions. EXCEPTION: A second ventilator for which prior authorization has been granted. See 78.10(5)*"k"* for prior authorization requirements.

f. Consideration will be given to rental or purchase based on the price of the item and the length of time it would be required. The decision on rental or purchase shall be made by the Iowa Medicaid enterprise and be based on the most reasonable method to provide the equipment.

(1) The provider shall monitor rental payments up to 100 percent of the purchase price. At the point that total rent paid equals 100 percent of the purchase allowance, the member will be considered to own the item and no further rental payments will be made to the provider.

(2) Payment may be made for the purchase of an item even though rental payments may have been made for prior months. The rental of the equipment may be necessary for a period of time to establish that it will meet the identified need before the purchase of the equipment. When a decision is made to purchase after renting an item, all of the rental payments will be applied to the purchase allowance.

(3) EXCEPTION: Ventilators and oxygen systems shall be maintained on a rental basis for the duration of use.

(4) A deposit shall not be charged by a provider to a Medicaid member or any other person on behalf of a Medicaid member for rental of medical equipment.

g. Payment may be made for necessary repair, maintenance, and supplies for member-owned equipment. No payment may be made for repairs, maintenance, or supplies when the member is renting the item.

h. Replacement of member-owned equipment is covered in cases of loss or irreparable damage or when required because of a change in the member's condition.

i. No allowance will be made for delivery, freight, postage, or other provider operating expenses for DME, prosthetic devices or medical supplies.

j. Reimbursement over the established fee schedule amount is allowed when prior authorization has been obtained. See 78.10(5)*"n"* for prior authorization requirements.

78.10(2) *Durable medical equipment.* DME is equipment that can withstand repeated use, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of an illness or injury, and is appropriate for use in the home.

a. Durable medical equipment provided in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability is not separately payable.

EXCEPTIONS:

(1) Oxygen services in a nursing facility or an intermediate care facility for persons with an intellectual disability when all of the following requirements and conditions have been met:

1. A Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile is completed by a physician, physician assistant, or advanced registered nurse practitioner and qualifies the member in accordance with Medicare criteria.

2. Additional documentation shows that the member requires oxygen for 12 hours or more per day for at least 30 days.

3. Oxygen logs must be maintained by the provider. The time between any reading shall not exceed more than 45 days. The documentation maintained in the provider record must contain the following:

- The initial, periodic and ending reading on the time meter clock on each oxygen system, and
- The dates of each initial, periodic and ending reading, and
- Evidence of ongoing need for oxygen services.

4. The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

5. Oxygen prescribed "PRN" or "as necessary" is not payable.

6. Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system and costs for servicing and repair of equipment are included in the Medicaid payment and shall not be separately payable.

7. Payment is not allowed for oxygen services that are not documented according to the department of inspections and appeals requirements at 481—subrule 58.21(8).

(2) Speech generating devices for which prior authorization has been obtained. See 78.10(5)*"f"* for prior authorization requirements.

(3) Wheelchairs for members in an intermediate care facility for persons with an intellectual disability.

(4) Medicaid will provide separate payment for customized wheelchairs for members who are residents of nursing facilities, subject to the following:

1. The member's condition must necessitate regular use of a wheelchair on a long-term basis to enable independent mobility within the facility.

2. The member must require a wheelchair that is designed, assembled, modified, or constructed for the specific individual, in whole or in part, based on the individual's condition, measurements, and needs.

3. Prior authorization pursuant to rule 441—79.8(249A) is required.

b. The types of durable medical equipment covered through the Medicaid program include, but are not limited to:

Automated medication dispenser. See 78.10(5)*"d"* for prior authorization requirements.

Bathtub/shower chair, bench. See 78.10(5)*"g"* and *"j"* for prior authorization requirements.

Commode, shower commode chair. See 78.10(5)*"j"* for prior authorization requirements.

Decubitus equipment.

Dialysis equipment.

Diaphragm (contraceptive device).

Enclosed bed. See 78.10(5)*"a"* for prior authorization requirements.

Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.

Heat/cold application device.

Hospital bed and accessories.

Inhalation equipment. See 78.10(5)*"c"* for prior authorization requirements.

Insulin infusion pump. See 78.10(5)*"b"* and 78.10(5)*"e"* for prior authorization requirements.

Lymphedema pump.

Mobility device and accessories. See 78.10(5)*"i"* for prior authorization requirements.

Neuromuscular stimulator.

Oximeter.

Oxygen, subject to the limitations in 78.10(2)*"a"* and 78.10(2)*"c."*

Patient lift. See 78.10(5)*"h"* for prior authorization requirements.

Phototherapy bilirubin light.

Protective helmet.

Seat lift chair.

Speech generating device. See 78.10(5)*"f"* for prior authorization requirements.

Traction equipment.

Ventilator.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary for members in accordance with Medicare criteria and as shown by supporting medical documentation. The physician, physician assistant, or advanced registered nurse practitioner shall document that other forms of treatment are contraindicated or have been tried and have not been successful and that oxygen therapy is required. EXCEPTION: Home oxygen equipment and oxygen are covered for children through three years of age when prescribed by a physician, physician assistant or advanced registered nurse practitioner. A pulse oximeter reading must be obtained yearly and documented in the provider and physician record.

(1) To identify the medical necessity for oxygen therapy, a Certificate of Medical Necessity for Oxygen, Form CMS-484, or a reasonable facsimile completed by a physician, physician assistant, or advanced registered nurse practitioner, shall qualify the member in accordance with Medicare criteria.

(2) If the member's condition or need for oxygen services changes, the attending physician, physician assistant, or advanced registered nurse practitioner must adjust the documentation accordingly.

(3) A second oxygen system is not covered by Medicaid when used as a backup for oxygen concentrators or as a standby in case of emergency. Members may be provided with a portable oxygen system to complement a stationary oxygen system, or to be used by itself, with documentation from the physician, physician assistant, or advanced registered nurse practitioner of the specific activities for which portable oxygen is medically necessary.

(4) Payment for oxygen systems shall be made only on a rental basis for the duration of use.

(5) All accessories, disposable supplies, servicing, and repairing of oxygen systems are included in the monthly Medicaid payment for oxygen systems.

(6) Oxygen prescribed "PRN" or "as necessary" is not allowed.

78.10(3) *Prosthetic devices.* Prosthetic devices mean replacement, corrective, or supportive devices prescribed by a physician (doctor of medicine, osteopathy or podiatry), physician assistant, or advanced registered nurse practitioner within the scope of practice as defined by state law to artificially replace a missing portion of the body, prevent or correct a physical deformity or malfunction, or support a weak or deformed portion of the body. This does not require a determination that there is no possibility that the member's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a member prior to the time the member undergoes a procedure which will make necessary the use of the device.

b. The types of prosthetic devices covered through the Medicaid program include, but are not limited to:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Enteral delivery supplies and products. See 78.10(5)*"l"* for prior authorization requirements.

(4) Hearing aids. See rule 441—78.14(249A).

(5) Orthotic devices. See 78.10(3)*"c"* for limitations on coverage of cranial orthotic devices.

(6) Ostomy appliances.

(7) Parenteral delivery supplies and products. Daily parenteral nutrition therapy is considered necessary and reasonable for a member with severe pathology of the alimentary tract that does not

allow absorption of sufficient nutrients to maintain weight and strength commensurate with the member's general condition.

(8) Prosthetic shoes, orthopedic shoes. See rule 441—78.15(249A).

(9) Tracheotomy tubes.

(10) Vibrotactile aids. Vibrotactile aids are payable only once in a four-year period unless the original aid is broken beyond repair or lost. (Cross reference 78.28(4))

c. Cranial orthotic device. Payment shall be approved for cranial orthotic devices when the device is medically necessary for the postsurgical treatment of synostotic plagiocephaly. Payment shall also be approved when there is documentation supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is 12 weeks of age but younger than 36 weeks of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is 36 weeks of age but younger than 108 weeks of age and there is documentation of either of the following conditions:

1. Cephalic index at least two standard deviations above the mean for the member's gender and age; or

2. Asymmetry of 12 millimeters or more in the cranial vault, skull base, or orbitotragial depth.

78.10(4) *Medical supplies.* Medical supplies are nondurable items consumed in the process of giving medical care, for example, nebulizers, gauze, bandages, sterile pads, adhesive tape, and sterile absorbent cotton. Medical supplies are payable for a specific medicinal purpose. This does not include food or drugs. However, active pharmaceutical ingredients and excipients that are identified as preferred on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A are covered. Medical supplies shall not be dispensed at any one time in quantities exceeding a 31-day supply for active pharmaceutical ingredients and excipients or a three-month supply for all other items. After the initial dispensing of medical supplies, the provider must document a refill request from the Medicaid member or the member's caregiver for each refill.

a. The types of medical supplies and supplies necessary for the effective use of a payable item covered through the Medicaid program include, but are not limited to:

Active pharmaceutical ingredients and excipients identified as preferred on the preferred drug list published pursuant to Iowa Code section 249A.20A.

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.

Diabetic supplies (including but not limited to blood glucose test strips, lancing devices, lancets, needles, syringes, and diabetic urine test supplies). See 78.10(5)*"e"* for prior authorization requirements.

Dialysis supplies.

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Incontinence products (for members three years of age and older).

Oral nutritional products. See 78.10(5)*"m"* for prior authorization requirements.

Ostomy appliances and supplies.

Respirator supplies.

Shoes, diabetic.

Surgical supplies.

Urinary collection supplies.

b. Only the following types of medical supplies will be approved for payment for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual

disability when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Diabetic supplies (including but not limited to lancing devices, lancets, needles and syringes, blood glucose test strips, and diabetic urine test supplies).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Ostomy appliances and supplies.

Shoes, diabetic.

78.10(5) *Prior authorization requirements.* Prior authorization pursuant to rule 441—79.8(249A) is required for the following medical equipment and supplies (Cross reference 78.28(1)):

a. Enclosed beds. Payment for an enclosed bed shall be approved when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The member's mobility puts the member at risk for injury.

b. External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

c. Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a member with a diagnosis of a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before the initiation of the vest demonstrate an overall significant decrease in lung function.

(2) The member resides in an independent living situation or has a medical condition that precludes the caregiver from administering traditional chest physiotherapy.

(3) Treatment by flutter device failed or is contraindicated.

(4) Treatment by intrapulmonary percussive ventilation failed or is contraindicated.

(5) All other less costly alternatives have been tried.

d. Automated medication dispenser. Payment will be approved for an automated medication dispenser when prescribed for a member who meets all of the following conditions:

(1) The member has a diagnosis indicative of cognitive impairment or age-related factors that affect the member's ability to remember to take medications.

(2) The member is on two or more medications prescribed to be administered more than one time per day.

(3) The availability of a caregiver to administer the medications or perform setup is limited or nonexistent.

(4) Less costly alternatives, such as medisets or telephone reminders, have failed.

e. Diabetic equipment and supplies. If the department has a current agreement for a rebate with at least one manufacturer of a particular category of diabetic equipment or supplies (by healthcare common procedure coding system (HCPCS) code), prior authorization is required for any equipment or supplies in that category produced by a manufacturer that does not have a current agreement to provide a rebate to the department (other than supplies for members receiving care in a nursing facility or an intermediate care facility for persons with an intellectual disability). Prior approval shall be granted when the member's medical condition necessitates use of equipment or supplies produced by a manufacturer that does not have a current rebate agreement with the department.

f. Speech generating device. Payment shall be approved according to Medicare coverage criteria. Form 470-2145, Speech Generating Device System Selection, completed by a speech-language pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted with the request for prior authorization. In addition, documentation from a speech-language pathologist must include information on the member's educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding

oral communication skills, prognosis with a particular device, and recommendations. A minimum one-month trial period is required for all devices. The Iowa Medicaid enterprise consultant with expertise in speech-language pathology will evaluate each prior authorization request and make recommendations to the department.

g. Bathtub/shower chair, bench. Payment shall be approved for specialized bath equipment for members whose medical condition necessitates additional body support while bathing.

h. Patient lift, nonstandard. Payment shall be approved for a nonstandard lift, such as a portable, ceiling or electric lifter, when the member meets the Medicare criteria for a patient lift and a standard lifter (Hoyer type) will not work.

i. Power wheelchair attendant control. Payment shall be approved when the member has a power wheelchair and:

(1) Has a sip ’n puff attachment, or

(2) The medical documentation demonstrates the member’s difficulty operating the wheelchair in tight space, or

(3) The medical documentation demonstrates the member becomes fatigued.

j. Shower commode chairs. Prior authorization shall be granted when documentation from a physician, physician assistant, advanced registered nurse practitioner, physical therapist or occupational therapist indicates that the member:

(1) Is unable to stand for the duration of a shower or is unable to get in or out of a bathtub, and

(2) Needs upper body support while sitting, and

(3) Needs to be tilted back for safety or pressure relief, if a tilt-in-space chair is requested.

k. Ventilator, secondary. Payment shall be approved according to the Medicare coverage criteria.

l. Enteral products and enteral delivery pumps and supplies. Payment shall be approved according to Medicare coverage criteria. EXCEPTION: The Medicare criteria for permanence is not required.

m. Oral nutritional products. Payment shall be approved when the member is not able to ingest or absorb sufficient nutrients from regular food due to a metabolic, digestive, or psychological disorder or pathology, to the extent that supplementation is necessary to provide 51 percent or more of the daily caloric intake, or when the use of oral nutritional products is otherwise determined medically necessary in accordance with evidence-based guidelines for treatment of the member’s condition. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for persons with an intellectual disability.

n. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved for bariatric equipment, pediatric equipment or other specialized medical equipment, supply, prosthetic or orthotic which:

(1) Meets the definition of a code in the current healthcare common procedure coding system (HCPCS), and

(2) Has an established Medicaid fee schedule amount that is inadequate to cover the provider’s cost to obtain the equipment or supply.

o. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2)*“a”*(4).

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 8993B**, IAB 8/11/10, effective 10/1/10; **ARC 9256B**, IAB 12/1/10, effective 1/1/11; **ARC 0632C**, IAB 3/6/13, effective 5/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 1151C**, IAB 10/30/13, effective 1/1/14]

441—78.11(249A) Ambulance service. Payment will be approved for ambulance service if it is required by the recipient’s condition and the recipient is transported to the nearest hospital with appropriate facilities or to one in the same locality, from one hospital to another, to the patient’s home or to a nursing facility. Payment for ambulance service to the nearest hospital for outpatient service will be approved only for emergency treatment. Ambulance service must be medically necessary and not merely for the convenience of the patient.

78.11(1) Partial payment may be made when an individual is transported beyond the destinations specified, and is limited to the amount that would have been paid had the individual been transported to

the nearest institution with appropriate facilities. When transportation is to the patient's home, partial payment is limited to the amount that would have been paid from the nearest institution with appropriate facilities. When a recipient who is a resident of a nursing care facility is hospitalized and later discharged from the hospital, payment will be made for the trip to the nursing care facility where the recipient resides even though it may not in fact be the nearest nursing care facility.

78.11(2) The Iowa Medicaid enterprise medical services unit shall determine that the ambulance transportation was medically necessary and that the condition of the patient precluded any other method of transportation. Payment can be made without the physician's confirmation when:

a. The individual is admitted as a hospital inpatient or in an emergency situation.

b. Previous information on file relating to the patient's condition clearly indicates ambulance service was necessary.

78.11(3) When a patient is transferred from one nursing home to another because of the closing of a facility or from a nursing home to a custodial home because the recipient no longer requires nursing care, the conditions of medical necessity and the distance requirements shall not be applicable. Approval for transfer shall be made by the local office of the department of human services prior to the transfer. When such a transfer is made, the following rate schedule shall apply:

One patient - normal allowance

Two patients - 3/4 normal allowance per patient

Three patients - 2/3 normal allowance per patient

Four patients - 5/8 normal allowance per patient

78.11(4) Transportation of hospital inpatients. When an ambulance service provides transport of a hospital inpatient to a provider and returns the recipient to the same hospital (the recipient continuing to be an inpatient of the hospital), the ambulance service shall bill the hospital for reimbursement as the hospital's DRG reimbursement system includes all costs associated with providing inpatient services as stated in 441—paragraph 79.1(5)*"j."*

78.11(5) In the event that more than one ambulance service is called to provide ground ambulance transport, payment shall be made only to one ambulance company. When a paramedic from one ambulance service joins a ground ambulance company already in transport, coverage is not available for the services and supplies provided by the paramedic.

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

441—78.12(249A) Behavioral health intervention. Payment will be made for behavioral health intervention services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a mental disorder, subject to the limitations in this rule.

78.12(1) *Definitions.*

"Behavioral health intervention" means skill-building services that focus on:

1. Addressing the mental and functional disabilities that negatively affect a member's integration and stability in the community and quality of life;

2. Improving a member's health and well-being related to the member's mental disorder by reducing or managing the symptoms or behaviors that prevent the member from functioning at the member's best possible functional level; and

3. Promoting a member's mental health recovery and resilience through increasing the member's ability to manage symptoms.

"Licensed practitioner of the healing arts" or *"LPHA,"* as used in this rule, means a practitioner such as a physician (M.D. or D.O.), a physician assistant (PA), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who is licensed by the applicable state authority for that profession.

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

"Mental disorder" means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American

Psychiatric Association, excluding intellectual disabilities, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention.

78.12(2) *Covered services.*

a. *Service setting.*

(1) Community-based behavioral health intervention is available to a member living in a community-based environment. Services have a primary goal of assisting the member and the member's family to learn age-appropriate skills to manage behavior and regain or retain self-control. Depending on the member's age and diagnosis, specific services offered may include:

1. Behavior intervention,
2. Crisis intervention,
3. Skill training and development, and
4. Family training.

(2) Residential behavioral health intervention is available to members eligible for foster group care payment pursuant to 441—subrule 156.20(1). Services have the primary goal of assisting the member to prepare to transition to the community through learning age-appropriate skills to manage behavior and regain or retain self-control. Specific services offered include:

1. Behavior intervention,
2. Crisis intervention, and
3. Family training.

(3) Behavioral health intervention is not covered for members who are in an acute care or psychiatric hospital, a long-term care facility, or a psychiatric medical institution for children.

b. *Crisis intervention.* Crisis intervention services shall provide a focused intervention and rapid stabilization of acute symptoms of mental illness or emotional distress. The intervention shall be designed to de-escalate situations in which a risk to self, others, or property exists.

(1) Services shall assist a member to regain self-control and reestablish effective management of behavioral symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Crisis intervention is covered only for Medicaid members who are aged 20 or under and shall be provided as outlined in a written treatment plan.

(3) Crisis intervention services do not include control room or other restraint activities.

c. *Behavior intervention.* Behavior intervention includes services designed to modify the psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning.

(1) Interventions may address the following skills for effective functioning with family, peers, and community in an age-appropriate manner:

1. Cognitive flexibility skills,
2. Communication skills,
3. Conflict resolution skills,
4. Emotional regulation skills,
5. Executive skills,
6. Interpersonal relationship skills,
7. Problem-solving skills, and
8. Social skills.

(2) Behavior intervention shall be provided in a location appropriate for skill identification, teaching and development. Intervention may be provided in an individual, family, or group format as appropriate to meet the member's needs.

(3) Behavior intervention is covered only for Medicaid members aged 20 or under.

(4) Covered services include only direct teaching or development of skills and not general recreation, non-skill-based activities, mentoring, or interruption of school.

d. *Family training.* Family training is covered only for Medicaid members aged 20 or under.

(1) Family training services shall:

1. Enhance the family's ability to effectively interact with the child and support the child's functioning in the home and community, and

2. Teach parents to identify and implement strategies to reduce target behaviors and reinforce the appropriate skills.

(2) Training provided must:

1. Be for the direct benefit of the member, and

2. Be based on a curriculum with a training manual.

e. Skill training and development. Skill training and development services are covered for Medicaid members aged 18 or over.

(1) Skill training and development shall consist of interventions to:

1. Enhance a member's independent living, social, and communication skills;

2. Minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and

3. Maximize a member's ability to live and participate in the community.

(2) Interventions may include training in the following skills for effective functioning with family, peers, and community:

1. Communication skills,

2. Conflict resolution skills,

3. Daily living skills,

4. Employment-related skills,

5. Interpersonal relationship skills,

6. Problem-solving skills, and

7. Social skills.

78.12(3) *Excluded services.*

a. Services that are habilitative in nature are not covered under behavioral health intervention. For purposes of this subrule, "habilitative services" means services that are designed to assist individuals in acquiring skills that they never had, as well as associated training to acquire self-help, socialization, and adaptive skills necessary to reside successfully in a home or community setting.

b. Respite, day care, education, and recreation services are not covered under behavioral health intervention.

78.12(4) *Coverage requirements.* Medicaid covers behavioral health intervention only when the following conditions are met:

a. A licensed practitioner of the healing arts acting within the practitioner's scope of practice under state law has diagnosed the member with a psychological disorder.

b. The licensed practitioner of the healing arts has recommended the behavioral health intervention as part of a plan of treatment designed to treat the member's psychological disorder. The plan of treatment shall be comprehensive in nature and shall detail all behavioral health services that the member may require, not only services included under behavioral health intervention.

(1) The member's need for services must meet specific individual goals that are focused to address:

1. Risk of harm to self or others,

2. Behavioral support in the community,

3. Specific skills impaired due to the member's mental illness, and

4. Needs of children at risk of out-of-home placement due to mental health needs or the transition back to the community or home following an out-of-home placement.

(2) Diagnosis and treatment plan development are covered services.

c. For a member under the age of 21, the licensed practitioner of the healing arts:

(1) Has, in cooperation with the managed care contractor, selected a standardized assessment instrument appropriate for baseline measurement of the member's current skill level in managing mental health needs;

(2) Has completed an initial formal assessment of the member using the instrument selected; and

(3) Completes a formal assessment every six months thereafter if continued services are ordered.

d. The behavioral health intervention provider has prepared a written services implementation plan that meets the requirements of subrule 78.12(5).

78.12(5) *Approval of plan.* The behavioral health intervention provider shall contact the Iowa Plan provider for authorization of the services.

a. *Initial plan.* The initial services implementation plan must meet all of the following criteria:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(6);

(2) The plan is consistent with the written diagnosis and treatment recommendations made by the licensed practitioner of the healing arts;

(3) The plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

(4) The provider meets the requirements of rule 441—77.12(249A); and

(5) The plan does not exceed six months' duration.

b. *Subsequent plans.* The Iowa Plan contractor may approve a subsequent services implementation plan according to the conditions in paragraph 78.12(5)*"a"* if the services are recommended by a licensed practitioner of the healing arts who has:

(1) Reexamined the member;

(2) Reviewed the original diagnosis and treatment plan; and

(3) Evaluated the member's progress, including a formal assessment as required by 78.12(4)*"c"*(3).

78.12(6) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of behavioral health intervention from the requirement that services be medically necessary. For purposes of behavioral health intervention, "medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition and specific to a daily impairment caused by a mental disorder;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of evidence-based medical practice. The standards of practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding evidence-based practices in the field.

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

[**ARC 8504B**, IAB 2/10/10, effective 3/22/10; **ARC 9487B**, IAB 5/4/11, effective 7/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.13(249A) Nonemergency medical transportation. The department makes available nonemergency medical transportation through a transportation brokerage. Medicaid members who are eligible for full Medicaid benefits and need transportation services so that they can receive Medicaid-covered services from providers enrolled with the Iowa Medicaid program may obtain transportation services consistent with this rule.

78.13(1) *Covered services.* Nonemergency medical transportation services available are limited to:

a. The most economical transportation appropriate to the needs of the member, provided to members eligible for nonemergency transportation when those members need transportation to providers enrolled in the Iowa Medicaid program for the receipt of goods or services covered by the Iowa Medicaid program. Consistent with the member's needs and subject to the limitations and restrictions set forth in this rule, subject to the advance approval of the broker, such transportation may include:

(1) Mileage reimbursement to the member, if the member is the driver.

(2) Mileage reimbursement to a volunteer or other responsible person, if the volunteer or other responsible person is the driver.

(3) Taxi service.

(4) Public transportation when public transportation is reasonably available and the member's condition does not preclude its use.

(5) Wheelchair and stretcher vans.

(6) Airfare costs when the most appropriate mode of transport is by air, based on the member's medical condition.

b. Reimbursement for costs of the member's meals necessary during periods of transportation and medical treatment.

c. Reimbursement of lodging expenses incurred by the member during periods of transportation and medical treatment.

d. Reimbursement of car rental costs incurred by the member during periods of transportation and medical treatment.

e. Reimbursement of a medically necessary escort's travel expenses when an escort is required because of the member's needs.

78.13(2) *Exclusions.* Nonemergency medical transportation is not available through the Iowa Medicaid program for:

a. Transportation to obtain services not covered by Iowa Medicaid;

b. Transportation to providers that are not enrolled in Iowa Medicaid;

c. Transportation for members residing in nursing facilities or ICF/ID facilities when such facilities provide the transportation (i.e., within 30 miles, one way, of the facility);

d. Transportation of family members to visit or participate in therapy when the member is hospitalized or institutionalized;

e. Transportation to durable medical equipment providers when such providers offer a delivery service that can be accessed at no cost to the member, unless the equipment requires a fitting that cannot be provided without transporting the member;

f. Reimbursement to HCBS and Medicaid providers for transportation provided as part of other covered services, such as personal care, home health, and supported community living services;

g. Transportation to a pharmacy that provides a free delivery service, with the exception of new prescription fills that are otherwise not available to the patient in the absence of nonemergency medical transportation services; and

h. Emergency transportation.

78.13(3) *Conditions and limitations on covered services.* Nonemergency medical transportation services are subject to the following limitations and conditions:

a. *Member request.* When a member needs nonemergency transportation to receive medical care provided by the Iowa Medicaid program, the member must contact the broker with as much advance notice as possible, but not more than 30 days' advance notice.

(1) Generally, members who require a ride from a transportation provider scheduled by the broker must contact the broker at least two business days in advance of the member's appointment to schedule the transportation. For purposes of calculating the two-business-day notice obligation, the advance notice includes the day of the medical appointment but not the day of the telephone call.

(2) If the member's nonemergency transportation need for a ride from a transportation provider scheduled by the broker makes the provision of two business days' notice impossible because of the member's urgent transportation need, the member must provide as much advance notice as is possible before the transportation need so that the broker can appropriately schedule the most economical form of transportation for the member. Urgent transportation needs for a ride from a transportation provider scheduled by the broker are limited to unscheduled episodic situations in which there is no immediate threat to life or limb but which require that the broker schedule transportation with less than two business days' notice. Examples of urgent trips include, but are not limited to:

1. Postsurgical or medical follow-up care specified by a health care provider;
2. Unexpected preoperative appointments;
3. Hospital discharges;
4. Appointments for new medical conditions or tests; and
5. Dialysis.

(3) The two-business-day advance notice obligation does not apply when the member requests only mileage reimbursement. To be eligible for mileage reimbursement:

1. The member must notify the broker no later than the day of the trip;

2. The transportation must be provided by a driver with a valid driver's license and insurance coverage on the vehicle at the time of the transport; and

3. The other requirements of rule 441—78.13(249A) must be met.

b. No free transportation alternatives available. Member transportation through the nonemergency medical transportation broker is not available to the member when the member is capable of securing the member's own transportation at no cost to the member (e.g., free-gas voucher programs).

c. No member transportation alternatives available. Members who have their own transportation available to them are required to use their own vehicle and seek mileage reimbursement. For purposes of determining whether or not the member has the member's own transportation that is available to the member, the broker shall take into consideration:

(1) Whether the member owns a vehicle;

(2) Whether a member-owned vehicle is in working mechanical order and is licensed;

(3) Whether the member has a valid driver's license and auto insurance;

(4) Whether the member is unable to drive because of age, physical condition, cognitive impairment, or developmental limitations; and

(5) Whether friends or family are available to transport the member to the member's medical appointment and receive mileage reimbursement.

d. Limitations on reimbursement for meals. Reimbursement for costs of members' meals necessary during periods of transportation and medical treatment is limited to situations in which:

(1) The transportation being provided spans the entire meal period;

(2) The one-way distance to or from the medical appointment is more than 50 miles;

(3) The meal is necessary to satisfy the needs of the member or medically necessary escort; and

(4) The meal reimbursement is limited to the subsistence allowance amounts applicable to state officers and state employees pursuant to Iowa Administrative Code rule 11—41.6(8A) and is supported by detailed receipts.

e. Limitations on reimbursement for lodging expenses. Reimbursement of lodging expenses incurred by members during periods of transportation and medical treatment is limited to reasonable reimbursement for expenses incurred by the member or the medically necessary escort, or both, during a nonemergency trip provided by the broker when the one-way distance to or from the medical appointment is more than 50 miles, supported by detailed receipts, and required for treatment.

f. Closest medical provider. Nonemergency medical transportation will only be provided to members to the closest qualified and enrolled Medicaid provider unless:

(1) The difference between the closest qualified and enrolled Medicaid provider and the enrolled provider requested by the member is less than 10 miles one way; or

(2) The additional cost of transportation to the enrolled provider requested by the member is medically justified based on:

1. The member's previous relationship with the requested provider; or

2. The member's prior experience with the requested provider; or

3. The requested provider's special expertise or experience; or

4. A referral requiring the member to be seen by the requested provider.

g. Member scheduling obligations. Members who require a ride will need to schedule medical appointments on days the transportation provider sends a shuttle to facilitate the provision of the most economical nonemergency medical transportation available, subject to reasonable medical exceptions.

h. Abusive behavior. Members who are abusive or inappropriate may be restricted by the department to only receiving mileage reimbursement. Such restricted members will be responsible for finding their own way to their medical appointments.

i. Member claim submission. Members must submit claims and supporting documentation to the broker within 120 days of the date of service. The broker shall deny member claims submitted more than 120 days from the date of service.

78.13(4) *Grievance procedure.* The broker shall establish an internal grievance procedure for members and transportation providers.

a. Members may appeal to the department pursuant to 441—Chapter 7 as an "aggrieved person."

b. Transportation providers.

(1) Consent for state fair hearing.

1. Transportation providers that are contracted with the broker and are in good standing with the broker may request a state fair hearing only for disputes regarding payment of claims, specifically, disputes concerning the denial of a claim or reduction in payment, and only when acting on behalf of the member.

2. The transportation provider requesting such a state fair hearing must have the prior, express, signed written consent of the member or the member's lawfully appointed guardian in order to request such a hearing. Notwithstanding any contrary provision in 441—Chapter 7, no state fair hearing will be granted unless the transportation provider submits a document providing such member approval with the request for a state fair hearing.

3. The document must specifically inform the member that protected health information (PHI) may be discussed at the hearing and may be made public in the course of the hearing and subsequent administrative and judicial proceedings. The document must contain language that indicates the knowledge of the potential for PHI to become public and that the member knowingly, voluntarily and intelligently consents to the network provider's bringing the state fair hearing on the member's behalf.

(2) For all transportation provider grievances not addressed by paragraph 78.13(4)*"b,"* the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

[**ARC 8344B**, IAB 12/2/09, effective 12/1/09; **ARC 8643B**, IAB 4/7/10, effective 3/11/10; **ARC 8994B**, IAB 8/11/10, effective 10/1/10; **ARC 1264C**, IAB 1/8/14, effective 3/1/14; **ARC 1976C**, IAB 4/29/15, effective 7/1/15]

441—78.14(249A) Hearing aids. Payment shall be approved for a hearing aid and examinations subject to the following conditions:

78.14(1) *Physician examination.* The member shall have an examination by a physician to determine that the member has no condition which would contraindicate the use of a hearing aid. This report shall be documented in the patient record. The requirement for a physician evaluation shall be waived for members 18 years of age or older when the member has signed an informed consent statement acknowledging that the member:

a. Has been advised that it may be in the member's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid.

b. Does not wish to receive a medical evaluation prior to purchase of a hearing aid.

78.14(2) *Audiological testings.* A physician or an audiologist shall perform audiological testing as a part of making a determination that a member could benefit from the use of a hearing aid. The department shall cover vestibular testing performed by an audiologist only when prescribed by a physician.

78.14(3) *Hearing aid evaluation.* A physician or an audiologist shall perform a hearing aid evaluation to establish if a member could benefit from a hearing aid. When a hearing aid is recommended for a member, the physician or audiologist recommending the hearing aid shall see the member at least one time within 30 days after purchase of the hearing aid to determine that the aid is adequate.

78.14(4) *Hearing aid selection.* A physician or audiologist may recommend a specific brand or model appropriate to the member's condition. When a physician or an audiologist makes a general hearing aid recommendation, a hearing aid dispenser may perform the tests to determine the specific brand or model appropriate to the member's condition.

78.14(5) *Travel.* When a member is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the member's place of residence or other suitable location. The department shall make payment to physicians as specified in 78.1(8) and payment to audiologists at the same rate it reimburses state employees for travel.

78.14(6) *Purchase of hearing aid.* The department shall pay for the type of hearing aid recommended when purchased from an eligible licensed hearing aid dispenser pursuant to rule 441—77.13(249A). The department shall pay for binaural amplification when:

a. A child needs the aid for speech development,

b. The aid is needed for educational or vocational purposes,

c. The aid is for a blind member,

d. The member's hearing loss has caused marked restriction of daily activities and constriction of interests resulting in seriously impaired ability to relate to other people, or

e. Lack of binaural amplification poses a hazard to a member's safety.

78.14(7) *Payment for hearing aids.*

a. Payment for hearing aids shall be acquisition cost plus a dispensing fee covering the fitting and service for six months. The department shall make payment for routine service after the first six months. Dispensing fees and payment for routine service shall not exceed the fee schedule appropriate to the place of service. Shipping and handling charges are not allowed.

b. Payment for ear mold and batteries shall be at the current audiologist's fee schedule.

c. Payment for repairs shall be made to the dealer for repairs made by the dealer. Payment for in-house repairs shall be made at the current fee schedule. Payment shall also be made to the dealer for repairs when the hearing aid is repaired by the manufacturer or manufacturer's depot. Payment for out-of-house repairs shall be at the amount shown on the manufacturer's invoice. Payment shall be allowed for a service or handling charge when it is necessary for repairs to be performed by the manufacturer or manufacturer's depot and this charge is made to the general public.

d. Prior approval. When prior approval is required, Form 470-4767, Examiner Report of Need for a Hearing Aid, shall be submitted along with the forms required by 441—paragraph 79.8(1)*"a."*

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the member is under 21 years of age. The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the member's hearing that would require a different hearing aid. (Cross reference 78.28(4)*"a"*)

(2) Payment for a hearing aid costing more than $650 shall require prior approval. The department shall approve payment for either of the following purposes (Cross reference 78.28(4)*"b"*):

1. Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

2. Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job, and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

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

[**ARC 8008B**, IAB 7/29/09, effective 8/1/09]

441—78.15(249A) Orthopedic shoes. Payment shall be approved only for depth or custom-molded orthopedic shoes, inserts, and modifications, subject to the following definitions and conditions.

78.15(1) *Definitions.*

"Custom-molded shoe" means a shoe that:

1. Has been constructed over a cast or model of the recipient's foot;

2. Is made of leather or another suitable material of equal quality;

3. Has inserts that can be removed, altered, or replaced according to the recipient's conditions and needs; and

4. Has some form of closure.

"Depth shoe" means a shoe that:

1. Has a full length, heel-to-toe filler that when removed provides a minimum of 3/16 inch of additional depth used to accommodate custom-molded or customized inserts;

2. Is made from leather or another suitable material of equal quality;

3. Has some form of closure; and

4. Is available in full and half sizes with a minimum of three widths, so that the sole is graded to the size and width of the upper portions of the shoe according to the American Standard last sizing schedule or its equivalent.

"Insert" means a foot mold or orthosis constructed of more than one layer of a material that:

1. Is soft enough and firm enough to take and hold an impression during use, and
2. Is molded to the recipient's foot or is made over a model of the foot.

78.15(2) *Prescription.* The recipient shall present to the provider a written prescription by a physician, a podiatrist, a physician assistant, or an advanced registered nurse practitioner that includes all of the following:

1. The date.
2. The patient's diagnosis.
3. The reason orthopedic shoes are needed.
4. The probable duration of need.
5. A specific description of any required modification of the shoes.

78.15(3) *Diagnosis.* The recipient shall have a diagnosis of an orthopedic, neuromuscular, vascular, or insensate foot condition, supported by applicable codes from the current version of the International Classification of Diseases (ICD). A diagnosis of flat feet is not covered.

a. A recipient with diabetes must meet the Medicare criteria for therapeutic depth and custom-molded shoes.

b. Custom-molded shoes are covered only when the recipient has a foot deformity and the provider has documentation of all of the following:

(1) The reasons the recipient cannot be fitted with a depth shoe.

(2) Pain.

(3) Tissue breakdown or a high probability of tissue breakdown.

(4) Any limitation on walking.

78.15(4) *Frequency.* Only two pairs of orthopedic shoes are allowed per recipient in a 12-month period unless documentation of change in size or evidence of excessive wear is submitted. EXCEPTION: School-aged children under the age of 21 may obtain athletic shoes in addition to the two pairs of shoes in a 12-month period.

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

441—78.16(249A) Community mental health centers. Payment will be approved for all reasonable and necessary services provided by a psychiatrist on the staff of a community mental health center. Payment will be approved for services provided by a clinical psychologist, social worker or psychiatric nurse on the staff of the center, subject to the following conditions:

78.16(1) Payment to a community mental health center will be approved for reasonable and necessary services provided to members by a psychiatrist, psychologist, social worker or psychiatric nurse on the staff of the center under the following conditions:

a. Services must be rendered under the supervision of a board-eligible or board-certified psychiatrist. All services must be performed under the supervision of a board-eligible or board-certified psychiatrist subject to the conditions set forth in 78.16(1)*"b"* with the following exceptions:

(1) Services by staff psychiatrists, or

(2) Services rendered by psychologists meeting the requirements of the National Register of Health Service Providers in Psychology, or

(3) Services provided by a staff member listed in this subrule performing the preliminary diagnostic evaluation of a member for voluntary admission to one of the state mental health institutes.

b. Supervisory process.

(1) Each patient shall have an initial evaluation completed which shall include at least one personal evaluation interview with a mental health professional, as defined under Iowa Code section 228.1. If the evaluation interview results indicate a need for an interview with a board-eligible or board-certified

psychiatrist, then such referral shall be made. This must be accomplished before submission of the first claim for services rendered to that patient.

(2) Ongoing review and assessment of patients' treatment needs, treatment plans, and the appropriateness of services rendered shall be assured through the peer review process in effect for community mental health centers, as directed by 2002 Iowa Acts, chapter 1120, section 13.

(3) and (4) Rescinded IAB 2/5/03, effective 2/1/03.

78.16(2) The treatment plans for and services rendered to patients of the center shall be evaluated and revised as necessary and appropriate, consistent with the standards of the peer review process described in subparagraph 78.16(1)*"b"*(1).

78.16(3) The peer review process and related activities, as described under subparagraph 78.16(1)*"b"*(1), are not payable as separate services under the Medicaid program. The center shall maintain the results of and information related to the peer review process, and these records shall be subject to audit by the department of human services or department designees, as necessary and appropriate.

78.16(4) Clinical records of medical assistance patients shall be available to the carrier on request. All these records shall be held confidential.

78.16(5) At the time of application for participation in the program the center will be provided with a form on which to list its professional staff. The center shall report acquisitions or losses of professional staff to the carrier within ten days.

78.16(6) Payment to a community mental health center will be approved for day treatment services for persons aged 21 or over if the center is certified by the department for day treatment services, the services are provided on the premises of the community mental health center or satellite office of the community mental health center, and the services meet the standards outlined herein.

a. Community mental health centers providing day treatment services for persons aged 21 or over shall have available a written narrative providing the following day treatment information:

(1) Documented need for day treatment services for persons aged 21 and over in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 21 and over that meet the day treatment program guidelines noted in 78.16(6)*"b."*

(3) Organization and staffing including how the day treatment program for persons aged 21 and over fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Day treatment services for persons aged 21 and over shall be structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression, and preventing hospitalization.

(1) Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions and training in medication management.

(2) Services are structured with an emphasis on program variation according to individual need.

(3) Services are provided for a period of three to five hours per day, three or four times per week.

c. Payment will be approved for day treatment services provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular, and documented. The employee or consultant shall meet the following minimum requirements:

(1) Have a bachelor's degree in a human services related field from an accredited college or university; or

(2) Have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services.

d. Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(7).

78.16(7) Payment to a community mental health center will be approved for day treatment services for persons aged 20 or under if the center is certified by the department for day treatment services and the services are provided on the premises of the community mental health center or satellite office of the community mental health center. Exception: Field trips away from the premises are a covered service when the trip is therapeutic and integrated into the day treatment program's description and milieu plan.

Day treatment coverage will be limited to a maximum of 15 hours per week. Day treatment services for persons aged 20 or under shall be outpatient services provided to persons who are not inpatients in a medical institution or residents of a group care facility licensed under 441—Chapter 114.

a. Program documentation. Community mental health centers providing day treatment services for persons aged 20 or under shall have available a written narrative which provides the following day treatment program information:

(1) Documented need for day treatment services for persons aged 20 or under in the area served by the program, including studies, needs assessments, and consultations with other health care professionals.

(2) Goals and objectives of the day treatment program for persons aged 20 or under that meet the guidelines noted in paragraphs *"c"* to *"h"* below.

(3) Organization and staffing including how the day treatment program for persons aged 20 or under fits with the rest of the community mental health center, the number of staff, staff credentials, and the staff's relationship to the program, e.g., employee, contractual, or consultant.

(4) Policies and procedures for the program including admission criteria, patient assessment, treatment plan, discharge plan, postdischarge services, and the scope of services provided.

(5) Any accreditations or other types of approvals from national or state organizations.

(6) The physical facility and any equipment to be utilized.

b. Program standards. Medicaid day treatment program services for persons aged 20 and under shall meet the following standards:

(1) Staffing shall:

1. Be sufficient to deliver program services and provide stable, consistent, and cohesive milieu with a staff-to-patient ratio of no less than one staff for each eight participants. Clinical, professional, and paraprofessional staff may be counted in determining the staff-to-patient ratio. Professional or clinical staff are those staff who are either mental health professionals as defined in rule 441—33.1(225C,230A) or persons employed for the purpose of providing offered services under the supervision of a mental health professional. All other staff (administrative, adjunctive, support, nonclinical, clerical, and consulting staff or professional clinical staff) when engaged in administrative or clerical activities shall not be counted in determining the staff-to-patient ratio or in defining program staffing patterns. Educational staff may be counted in the staff-to-patient ratio.

2. Reflect how program continuity will be provided.

3. Reflect an interdisciplinary team of professionals and paraprofessionals.

4. Include a designated director who is a mental health professional as defined in rule 441—33.1(225C,230A). The director shall be responsible for direct supervision of the individual treatment plans for participants and the ongoing assessment of program effectiveness.

5. Be provided by or under the general supervision of a mental health professional as defined in rule 441—33.1(225C,230A). When services are provided by an employee or consultant of the community mental health center who is not a mental health professional, the employee or consultant shall be supervised by a mental health professional who gives direct professional direction and active guidance to the employee or consultant and who retains responsibility for consumer care. The supervision shall be timely, regular and documented. The employee or consultant shall have a bachelor's degree in a human services related field from an accredited college or university or have an Iowa license to practice as a registered nurse with two years of experience in the delivery of nursing or human services. Exception: Other certified or licensed staff, such as certified addiction counselors or certified

occupational and recreational therapy assistants, are eligible to provide direct services under the general supervision of a mental health professional, but they shall not be included in the staff-to-patient ratio.

(2) There shall be written policies and procedures addressing the following: admission criteria; patient assessment; patient evaluation; treatment plan; discharge plan; community linkage with other psychiatric, mental health, and human service providers; a process to review the quality of care being provided with a quarterly review of the effectiveness of the clinical program; postdischarge services; and the scope of services provided.

(3) The program shall have hours of operation available for a minimum of three consecutive hours per day, three days or evenings per week.

(4) The length of stay in a day treatment program for persons aged 20 or under shall not exceed 180 treatment days per episode of care, unless the rationale for a longer stay is documented in the patient's case record and treatment plan every 30 calendar days after the first 180 treatment days.

(5) Programming shall meet the individual needs of the patient. A description of services provided for patients shall be documented along with a schedule of when service activities are available including the days and hours of program availability.

(6) There shall be a written plan for accessing emergency services 24 hours a day, seven days a week.

(7) The program shall maintain a community liaison with other psychiatric, mental health, and human service providers. Formal relationships shall exist with hospitals providing inpatient programs to facilitate referral, communication, and discharge planning. Relationships shall also exist with appropriate school districts and educational cooperatives. Relationships with other entities such as physicians, hospitals, private practitioners, halfway houses, the department, juvenile justice system, community support groups, and child advocacy groups are encouraged. The provider's program description will describe how community links will be established and maintained.

(8) Psychotherapeutic treatment services and psychosocial rehabilitation services shall be available. A description of the services shall accompany the application for certification.

(9) The program shall maintain a distinct clinical record for each patient admitted. Documentation, at a minimum, shall include: the specific services rendered, the date and actual time services were rendered, who rendered the services, the setting in which the services were rendered, the amount of time it took to deliver the services, the relationship of the services to the treatment regimen described in the plan of care, and updates describing the patient's progress.

c. *Program services.* Day treatment services for persons aged 20 or under shall be a time-limited, goal-oriented active treatment program that offers therapeutically intensive, coordinated, structured clinical services within a stable therapeutic milieu. Time-limited means that the patient is not expected to need services indefinitely or lifelong, and that the primary goal of the program is to improve the behavioral functioning or emotional adjustment of the patient in order that the service is no longer necessary. Day treatment services shall be provided within the least restrictive therapeutically appropriate context and shall be community-based and family focused. The overall expected outcome is clinically adaptive behavior on the part of the patient and the family.

At a minimum, day treatment services will be expected to improve the patient's condition, restore the condition to the level of functioning prior to onset of illness, control symptoms, or establish and maintain a functional level to avoid further deterioration or hospitalization. Services are expected to be age-appropriate forms of psychosocial rehabilitation activities, psychotherapeutic services, social skills training, or training in basic care activities to establish, retain or encourage age-appropriate or developmentally appropriate psychosocial, educational, and emotional adjustment.

Day treatment programs shall use an integrated, comprehensive and complementary schedule of therapeutic activities and shall have the capacity to treat a wide array of clinical conditions.

The following services shall be available as components of the day treatment program. These services are not separately billable to Medicaid, as day treatment reimbursement includes reimbursement for all day treatment components.

(1) Psychotherapeutic treatment services (examples would include individual, group, and family therapy).

(2) Psychosocial rehabilitation services. Active treatment examples include, but are not limited to, individual and group therapy, medication evaluation and management, expressive therapies, and theme groups such as communication skills, assertiveness training, other forms of community skills training, stress management, chemical dependency counseling, education, and prevention, symptom recognition and reduction, problem solving, relaxation techniques, and victimization (sexual, emotional, or physical abuse issues).

Other program components may be provided, such as personal hygiene, recreation, community awareness, arts and crafts, and social activities designed to improve interpersonal skills and family mental health. Although these other services may be provided, they are not the primary focus of treatment.

(3) Evaluation services to determine need for day treatment prior to program admission. For persons for whom clarification is needed to determine whether day treatment is an appropriate therapy approach, or for persons who do not clearly meet admission criteria, an evaluation service may be performed. Evaluation services shall be individual and family evaluation activities made available to courts, schools, other agencies, and individuals upon request, who assess, plan, and link individuals with appropriate services. This service must be completed by a mental health professional. An evaluation from another source performed within the previous 12 months or sooner if there has not been a change may be substituted. Medicaid will not make separate payment for these services under the day treatment program.

(4) Assessment services. All day treatment patients will receive a formal, comprehensive biopsychosocial assessment of day treatment needs including, if applicable, a diagnostic impression based on the current Diagnostic and Statistical Manual of Mental Disorders. An assessment from another source performed within the previous 12 months may be used if the symptomatology is the same as 12 months ago. If not, parts of the assessment which reflect current functioning may be used as an update. Using the assessment, a comprehensive summation will be produced, including the findings of all assessments performed. The summary will be used in forming a treatment plan including treatment goals. Indicators for discharge planning, including recommended follow-up goals and provision for future services, should also be considered, and consistently monitored.

(5) The day treatment program may include an educational component as an additional service. The patient's educational needs shall be served without conflict from the day treatment program. Hours in which the patient is involved in the educational component of the day treatment program are not included in the day treatment hours billable to Medicaid.

d. Admission criteria. Admission criteria for day treatment services for persons aged 20 or under shall reflect the following clinical indicators:

(1) The patient is at risk for exclusion from normative community activities or residence.

(2) The patient exhibits psychiatric symptoms, disturbances of conduct, decompensating conditions affecting mental health, severe developmental delays, psychological symptoms, or chemical dependency issues sufficiently severe to bring about significant or profound impairment in day-to-day educational, social, vocational, or interpersonal functioning.

(3) Documentation is provided that the traditional outpatient setting has been considered and has been determined not to be appropriate.

(4) The patient's principal caretaker (family, guardian, foster family or custodian) must be able and willing to provide the support and monitoring of the patient, to enable adequate control of the patient's behavior, and must be involved in the patient's treatment. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

(5) The patient has the capacity to benefit from the interventions provided.

e. Individual treatment plan. Each patient receiving day treatment services shall have a treatment plan prepared. A preliminary treatment plan should be formulated within 3 days of participation after admission, and replaced within 30 calendar days by a comprehensive, formalized plan utilizing the comprehensive assessment. This individual treatment plan should reflect the patient's strengths and weaknesses and identify areas of therapeutic focus. The treatment goals which are general statements of consumer outcomes shall be related to identified strengths, weaknesses, and clinical needs

with time-limited, measurable objectives. Objectives shall be related to the goal and have specific anticipated outcomes. Methods that will be used to pursue the objectives shall be stated. The plan should be reviewed and revised as needed, but shall be reviewed at least every 30 calendar days. The treatment plan shall be developed or approved by a board-eligible or board-certified psychiatrist, a staff psychiatrist, physician, or a psychologist registered either on the "National Register of Health Service Providers in Psychology" or the "Iowa Register of Health Service Providers for Psychology." Approval will be evidenced by a signature of the physician or health service provider.

f. *Discharge criteria.* Discharge criteria for the day treatment program for persons aged 20 or under shall incorporate at least the following indicators:

(1) In the case of patient improvement:

1. The patient's clinical condition has improved as shown by symptom relief, behavioral control, or indication of mastery of skills at the patient's developmental level. Reduced interference with and increased responsibility with social, vocational, interpersonal, or educational goals occurs sufficient to warrant a treatment program of less supervision, support, and therapeutic intervention.

2. Treatment goals in the individualized treatment plan have been achieved.

3. An aftercare plan has been developed that is appropriate to the patient's needs and agreed to by the patient and family, custodian, or guardian.

(2) If the patient does not improve:

1. The patient's clinical condition has deteriorated to the extent that the safety and security of inpatient or residential care is necessary.

2. Patient, family, or custodian noncompliance with treatment or with program rules exists.

g. *Coordination of services.* Programming services shall be provided in accordance with the individual treatment plan developed by appropriate day treatment staff, in collaboration with the patient and appropriate caretaker figure (parent, guardian, or principal caretaker), and under the supervision of the program director, coordinator, or supervisor.

The program for each patient will be coordinated by primary care staff of the community mental health center. A coordinated, consistent array of scheduled therapeutic services and activities shall comprise the day treatment program. These may include counseling or psychotherapy, theme groups, social skills development, behavior management, and other adjunctive therapies. At least 50 percent of scheduled therapeutic program hours exclusive of educational hours for each patient shall consist of active treatment that specifically addresses the targeted problems of the population served. Active treatment shall be defined as treatment in which the program staff assume significant responsibility and often intervene.

Family, guardian, or principal caretaker shall be involved with the program through family therapy sessions or scheduled family components of the program. They will be encouraged to adopt an active role in treatment. Medicaid will not make separate payment for family therapy services. Persons aged 20 or under who have reached the age of majority, either by age or emancipation, are exempt from family therapy involvement.

Therapeutic activities will be scheduled according to the needs of the patients, both individually and as a group.

Scheduled therapeutic activities, which may include other program components as described above, shall be provided at least 3 hours per week up to a maximum of 15 hours per week.

h. *Stable milieu.* The program shall formally seek to provide a stable, consistent, and cohesive therapeutic milieu. In part this will be encouraged by scheduling attendance such that a stable core of patients exists as much as possible. The milieu will consider the developmental and social stage of the participants such that no patient will be significantly involved with other patients who are likely to contribute to retardation or deterioration of the patient's social and emotional functioning. To help establish a sense of program identity, the array of therapeutic interventions shall be specifically identified as the day treatment program. Program planning meetings shall be held at least quarterly to evaluate the effectiveness of the clinical program. In the program description, the provider shall state how milieu stability will be provided.

i. *Chronic mental illness.* Persons aged 18 through 20 with chronic mental illness as defined by rule 441—24.1(225C) can receive day treatment services under this subrule or subrule 78.16(6).

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

441—78.17(249A) Physical therapists. Payment will be approved for the same services payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.18(249A) Screening centers. Payment will be approved for health screening as defined in 441—subrule 84.1(1) for Medicaid members under 21 years of age.

78.18(1) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a screening center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.18(2) Payment will be approved for necessary laboratory service related to an element of screening when performed by the screening center and billed as a separate item.

78.18(3) Periodicity schedules for health, hearing, vision, and dental screenings.

a. Payment will be approved for health, vision, and hearing screenings as follows:

(1) Six screenings in the first year of life.

(2) Four screenings between the ages of 1 and 2.

(3) One screening a year at ages 3, 4, 5, and 6.

(4) One screening a year at ages 8, 10, 12, 14, 16, 18, and 20.

b. Payment for dental screenings will be approved in conjunction with the health screenings up to age 12 months. Screenings will be approved at ages 12 months and 24 months and thereafter at six-month intervals up to age 21.

c. Interperiodic screenings will be approved as medically necessary.

78.18(4) When it is established by the periodicity schedule in 78.18(3) that an individual is in need of screening the individual will receive a notice that screening is due.

78.18(5) When an individual is screened, a member of the screening center shall complete a medical history. The medical history shall become part of the individual's medical record.

78.18(6) Rescinded IAB 12/3/08, effective 2/1/09.

78.18(7) Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a screening center for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.18(8) Payment shall be made for dental services provided by a dental hygienist employed by or under contract with a screening center.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.19(249A) Rehabilitation agencies.

78.19(1) *Coverage of services.*

a. *General provisions regarding coverage of services.*

(1) Services are provided in the member's home or in a care facility (other than a hospital) by a speech therapist, physical therapist, or occupational therapist employed by or contracted by the agency. Services provided to a member residing in a residential care facility are payable when the facility submits a signed statement that the facility does not have these services available. The statement need only be submitted at the start of care unless the situation changes. Payment will not be made to a rehabilitation agency for therapy provided to a member residing in a nursing facility or an intermediate care facility for persons with an intellectual disability since these facilities are responsible for providing or paying for services required by members.

(2) All services must be determined to be medically necessary, reasonable, and meet a significant need of the recipient that cannot be met by a family member, friend, medical staff personnel, or other caregiver; must meet accepted standards of medical practice; and must be a specific and effective treatment for a patient's medical or disabling condition.

(3) In order for a service to be payable, a licensed therapist must complete a plan of treatment every 30 days and indicate the type of service required. The plan of treatment must contain the information noted in subrule 78.19(2).

(4) There is no specific limitation on the number of visits for which payment through the program will be made so long as that amount of service is medically necessary in the individual case, is related to a diagnosed medical impairment or disabling condition, and meets the current standards of practice in each related field. Documentation must be submitted with each claim to support the need for the number of services being provided.

(5) Payments will be made both for restorative service and also for maintenance types of service. Essentially, maintenance services means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This would include persons with long-term illnesses or a disabling condition whose status is stable rather than posthospital. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(6) Restorative or maintenance therapy sessions must meet the following criteria:

1. There must be face-to-face patient contact interaction.

2. Services must be provided primarily on an individual basis. Group therapy is covered, but total units of service in a month shall not exceed total units of individual therapy. Family members receiving therapy may be included as part of a group.

3. Treatment sessions may be no less than 15 minutes of service and no more than 60 minutes of service per date unless more than 60 minutes of service is required for a treatment session due to the patient's specific condition. If more than 60 minutes of service is required for a treatment session, additional documentation of the specific condition and the need for the longer treatment session shall be submitted with the claim. A unit of treatment shall be considered to be 15 minutes in length.

4. Progress must be documented in measurable statistics in the progress notes in order for services to be reimbursed. Refer to 78.19(1)*"b"*(7) and (8) for guidelines under restorative and maintenance therapy.

(7) Payment will be made for an appropriate period of diagnostic therapy or trial therapy (up to two months) to determine a patient's rehabilitation potential and establish appropriate short-term and long-term goals. Documentation must be submitted with each plan to support the need for diagnostic or trial therapy. Refer to 78.19(1)*"b"*(16) for guidelines under diagnostic or trial therapy.

b. Physical therapy services.

(1) To be covered under rehabilitation agency services, physical therapy services must relate directly and specifically to an active written treatment plan, follow a treatment plan established by the licensed therapist after consultation with the physician, be reasonable and necessary to the treatment of the person's illness, injury, or disabling condition, be specific and effective treatment for the patient's medical or disabling condition, and be of such a level of complexity and sophistication, or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified physical therapist or under the supervision of the therapist.

(2) A qualified physical therapist assistant may provide any restorative services performed by a licensed physical therapist under supervision of the therapist as set forth in the department of public health, professional licensure division, 645—subrule 200.20(7).

(3) The initial physical therapy evaluation must be provided by a licensed physical therapist.

(4) There must be an expectation that there will be a significant, practical improvement in the patient's condition in a reasonable amount of time based on the patient's restorative potential assessed by the physician.

(5) It must be demonstrated there is a need to establish a safe and effective maintenance program related to a specific disease state, illness, injury, or disabling condition.

(6) The amount, frequency, and duration of the services must be reasonable.

(7) Restorative therapy must be reasonable and necessary to the treatment of the patient's injury or disabling condition. The expected restorative potential must be practical and in relation to the extent and duration of the treatment. There must be an expectation that the patient's medical or disabling condition will show functional improvement in a reasonable period of time. Functional improvement means that demonstrable measurable increases have occurred in the patient's level of independence outside the therapeutic environment.

(8) Generally, maintenance therapy means services to a patient whose condition is stabilized and who requires observation by a therapist of conditions defined by the physician as indicating a possible deterioration of health status. This includes persons with long-term illnesses or disabling conditions whose status is stable rather than posthospital. Maintenance therapy is also appropriate for individuals whose condition is such that a professionally established program of activities, exercises, or stimulation is medically necessary to prevent deterioration or maintain present functioning levels.

Where a maintenance program is appropriate, the initial evaluation and the instruction of the patient, family members, home health aides, facility personnel, or other caregivers to carry out the program are considered a covered physical therapy service. Payment shall be made for a maximum of three visits to establish a maintenance program and instruct the caregivers. Payment for supervisory visits to monitor the program is limited to two per month for a maximum period of 12 months. The plan of treatment must specify the anticipated monitoring activity of the supervisor.

Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable.

After 12 months of maintenance therapy, a reevaluation is a covered service, if medically necessary. A reevaluation will be considered medically necessary only if there is a significant change in residential or employment situation or the patient exhibits an increase or decrease in functional ability or motivation, clearing of confusion, or the remission of some other medical condition which previously contraindicated restorative therapy. A statement by the interdisciplinary team of a person with developmental disabilities recommending a reevaluation and stating the basis for medical necessity will be considered as supporting the necessity of a reevaluation and may expedite approval.

(Restorative and maintenance therapy definitions also apply to speech and occupational therapy.)

When a patient is under a restorative physical therapy program, the patient's condition is regularly reevaluated and the program adjusted by the physical therapist. It is expected that prior to discharge, a maintenance program has been designed by the physical therapist. Consequently, where a maintenance program is not established until after the restorative program has been completed, it would not be considered reasonable and necessary to the treatment of the patient's condition and would be excluded from coverage.

(9) Hot packs, hydrocollator, infrared treatments, paraffin baths, and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. These are covered when the patient's condition is complicated by other conditions such as a circulatory deficiency or open wounds or if the service is an integral part of a skilled physical therapy procedure.

(10) Gait training and gait evaluation and training constitute a covered service if the patient's ability to walk has been impaired by a neurological, muscular or skeletal condition or illness. The gait training must be expected to significantly improve the patient's ability to walk or level of independence.

Repetitious exercise to increase endurance of weak or unstable patients can be safely provided by supportive personnel, e.g., aides, nursing personnel. Therefore, it is not a covered physical therapy service.

(11) Ultrasound, shortwave, and microwave diathermy treatments are considered covered services.

(12) Range of motion tests must be performed by a qualified physical therapist. Range of motion exercises require the skills of a qualified physical therapist only when they are part of the active treatment of a specific disease or disabling condition which has resulted in a loss or restriction of mobility.

Documentation must reflect the degree of motion lost, the normal range of motion, and the degree to be restored.

Range of motion to unaffected joints only does not constitute a covered physical therapy service.

(13) Reconditioning programs after surgery or prolonged hospitalization are not covered as physical therapy.

(14) Therapeutic exercises would constitute a physical therapy service due either to the type of exercise employed or to the condition of the patient.

(15) Use of isokinetic or isotonic type equipment in physical therapy is covered when normal range of motion of a joint is affected due to bone, joint, ligament or tendon injury or postsurgical trauma. Billing can only be made for the time actually spent by the therapist in instructing the patient and assessing the patient's progress.

(16) When recipients do not meet restorative or maintenance therapy criteria, diagnostic or trial therapy may be utilized. When the initial evaluation is not sufficient to determine whether there are rehabilitative goals that should be addressed, diagnostic or trial therapy to establish goals shall be considered appropriate. Diagnostic or trial therapy may be appropriate for recipients who need evaluation in multiple environments in order to adequately determine their rehabilitative potential. Diagnostic or trial therapy consideration may be appropriate when there is a need to assess the patient's response to treatment in the recipient's environment.

When during diagnostic or trial therapy a recipient has been sufficiently evaluated to determine potential for restorative or maintenance therapy, or lack of therapy potential, diagnostic or trial therapy ends. When as a result of diagnostic or trial therapy, restorative or maintenance therapy is found appropriate, claims shall be submitted noting restorative or maintenance therapy (instead of diagnostic or trial therapy).

At the end of diagnostic or trial therapy, the rehabilitation provider shall recommend continuance of services under restorative therapy, recommend continuance of services under maintenance therapy, or recommend discontinuance of services. Continuance of services under restorative or maintenance therapy will be reviewed based on the criteria in place for restorative or maintenance therapy.

Trial therapy shall not be granted more often than once per year for the same issue. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. Requests for subsequent diagnostic or trial therapy for the same issue would require documentation reflecting a significant change. See number 4 below for guidelines under a significant change. Further diagnostic or trial therapy for the same issue would not be considered appropriate when progress was not achieved, unless the reasons which blocked change previously are listed and the reasons the new diagnostic or trial therapy would not have these blocks are provided.

The number of diagnostic or trial therapy hours authorized in the initial treatment period shall not exceed 12 hours per month. Documentation of the medical necessity and the plan for services under diagnostic trial therapy are required as they will be reviewed in the determination of the medical necessity of the number of hours of service provided.

Diagnostic or trial therapy standards also apply to speech and occupational therapy.

The following criteria additionally must be met:

1. There must be face-to-face interaction with a licensed therapist. (An aide's services will not be payable.)

2. Services must be provided on an individual basis. (Group diagnostic or trial therapy will not be payable.)

3. Documentation of the diagnostic therapy or trial therapy must reflect the provider's plan for therapy and the recipient's response.

4. If the recipient has a previous history of rehabilitative services, trial therapy for the same type of services generally would be payable only when a significant change has occurred since the last therapy. A significant change would be considered as having occurred when any of the following exist: new onset, new problem, new need, new growth issue, a change in vocational or residential setting that requires a reevaluation of potential, or surgical intervention that may have caused new rehabilitative potentials.

5. For persons who received previous rehabilitative treatment, consideration of trial therapy generally should occur only if the person has incorporated any regimen recommended during prior treatment into the person's daily life to the extent of the person's abilities.

6. Documentation should include any previous attempts to resolve problems using nontherapy personnel (i.e., residential group home staff, family members, etc.) and whether follow-up programs from previous therapy have been carried out.

7. Referrals from residential, vocational or other rehabilitation personnel that do not meet present evaluation, restorative or maintenance criteria shall be considered for trial therapy. Documentation of the proposed service, the medical necessity and the current medical or disabling condition, including any secondary rehabilitative diagnosis, will need to be submitted with the claim.

8. Claims for diagnostic or trial therapy shall reflect the progress being made toward the initial diagnostic or trial therapy plan.

c. Occupational therapy services.

(1) To be covered under rehabilitation agency services, occupational therapy services must be included in a plan of treatment, improve or restore practical functions which have been impaired by illness, injury, or disabling condition, or enhance the person's ability to perform those tasks required for independent functioning, be prescribed by a physician under a plan of treatment, be performed by a qualified licensed occupational therapist or a qualified licensed occupational therapist assistant under the general supervision of a qualified licensed occupational therapist as set forth in the department of public health, professional licensure division, rule 645—201.9(148B), and be reasonable and necessary for the treatment of the person's illness, injury, or disabling condition.

(2) Restorative therapy is covered when an expectation exists that the therapy will result in a significant practical improvement in the person's condition.

However, in these cases where there is a valid expectation of improvement met at the time the occupational therapy program is instituted, but the expectation goal is not realized, services would only be covered up to the time one would reasonably conclude the patient would not improve.

The guidelines under restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to occupational therapy.

(3) Maintenance therapy, or any activity or exercise program required to maintain a function at the restored level, is not a covered service. However, designing a maintenance program in accordance with the requirements of 78.19(1)*"b"*(8) and monitoring the progress would be covered.

(4) The selection and teaching of tasks designed to restore physical function are covered.

(5) Planning and implementing therapeutic tasks, such as activities to restore sensory-integrative functions are covered. Other examples include providing motor and tactile activities to increase input and improve responses for a stroke patient.

(6) The teaching of activities of daily living and energy conservation to improve the level of independence of a patient which require the skill of a licensed therapist and meet the definition of restorative therapy is covered.

(7) The designing, fabricating, and fitting of orthotic and self-help devices are considered covered services if they relate to the patient's condition and require occupational therapy. A maximum of 13 visits is reimbursable.

(8) Vocational and prevocational assessment and training are not payable by Medicaid. These include services which are related solely to specific employment opportunities, work skills, or work settings.

d. Speech therapy services.

(1) To be covered by Medicaid as rehabilitation agency services, speech therapy services must be included in a plan of treatment established by the licensed, skilled therapist after consultation with the physician, relate to a specific medical diagnosis which will significantly improve a patient's practical, functional level in a reasonable and predictable time period, and require the skilled services of a speech therapist. Services provided by a speech aide are not reimbursable.

(2) Speech therapy activities which are considered covered services include: restorative therapy services to restore functions affected by illness, injury, or disabling condition resulting in a communication impairment or to develop functions where deficiencies currently exist. Communication impairments fall into the general categories of disorders of voice, fluency, articulation, language, and

swallowing disorders resulting from any condition other than mental impairment. Treatment of these conditions is payable if restorative criteria are met.

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

(4) Teaching a patient to use sign language and to use an augmentative communication device is reimbursable. The patient must show significant progress outside the therapy sessions in order for these services to be reimbursable.

(5) Where a maintenance program is appropriate, the initial evaluation, the instruction of the patient and caregivers to carry out the program, and supervisory visits to monitor progress are covered services. Beyond evaluation, instruction, and monitoring, maintenance therapy is not reimbursable. However, designing a maintenance program in accordance with the requirements of maintenance therapy and monitoring the progress are covered.

(6) The guidelines and limits on restorative therapy, maintenance therapy, and diagnostic or trial therapy for physical therapy in 78.19(1)*"b"*(7), (8), and (16) apply to speech therapy. If the only goal of prior rehabilitative speech therapy was to learn the prerequisite speech components, then number "5" under 78.19(1)*"b"*(16) will not apply to trial therapy.

78.19(2) *General guidelines for plans of treatment.*

a. The minimum information to be included on medical information forms and treatment plans includes:

(1) The patient's current medical condition and functional abilities, including any disabling condition.

(2) The physician's signature and date (within the certification period).

(3) Certification period.

(4) Patient's progress in measurable statistics. (Refer to 78.19(1)*"b"*(16).)

(5) The place services are rendered.

(6) Dates of prior hospitalization (if applicable or known).

(7) Dates of prior surgery (if applicable or known).

(8) The date the patient was last seen by the physician (if available).

(9) A diagnosis relevant to the medical necessity for treatment.

(10) Dates of onset of any diagnoses for which treatment is being rendered (if applicable).

(11) A brief summary of the initial evaluation or baseline.

(12) The patient's prognosis.

(13) The services to be rendered.

(14) The frequency of the services and discipline of the person providing the service.

(15) The anticipated duration of the services and the estimated date of discharge (if applicable).

(16) Assistive devices to be used.

(17) Functional limitations.

(18) The patient's rehabilitative potential and the extent to which the patient has been able to apply the skills learned in the rehabilitation setting to everyday living outside the therapy sessions.

(19) The date of the last episode of instability or the date of the last episode of acute recurrence of illness or symptoms (if applicable).

(20) Quantitative, measurable, short-term and long-term functional goals.

(21) The period of time of a session.

(22) Prior treatment (history related to current diagnosis) if available or known.

b. The information to be included when developing plans for teaching, training, and counseling include:

(1) To whom the services were provided (patient, family member, etc.).

(2) Prior teaching, training, or counseling provided.

(3) The medical necessity of the rendered services.

(4) The identification of specific services and goals.

(5) The date of the start of the services.
(6) The frequency of the services.
(7) Progress in response to the services.
(8) The estimated length of time the services are needed.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 0994C**, IAB 9/4/13, effective 11/1/13]

441—78.20(249A) Independent laboratories. Payment will be made for medically necessary laboratory services provided by laboratories that are independent of attending and consulting physicians' offices, hospitals, and critical access hospitals and that are certified to participate in the Medicare program.

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

441—78.21(249A) Rural health clinics. Payment will be made to rural health clinics for the same services payable under the Medicare program (Title XVIII of the Social Security Act). Payment will be made for sterilization in accordance with 78.1(16).

78.21(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.21(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.21(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a rural health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.22(249A) Family planning clinics. Payments will be made on a fee schedule basis for services provided by family planning clinics.

78.22(1) Payment will be made for sterilization in accordance with 78.1(16).

78.22(2) In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a family planning clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.23(249A) Other clinic services. Payment will be made on a fee schedule basis to facilities not part of a hospital, funded publicly or by private contributions, which provide medically necessary treatment by or under the direct supervision of a physician or dentist to outpatients.

78.23(1) *Sterilization.* Payment will be made for sterilization in accordance with 78.1(16).

78.23(2) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.23(3) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.23(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a clinic must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.24(249A) Psychologists. Payment will be approved for services authorized by state law when they are provided by the psychologist in the psychologist's office, a hospital, nursing facility, or residential care facility.

78.24(1) Payment for covered services provided by the psychologist shall be made on a fee for service basis.

a. Payment shall be made only for time spent in face-to-face consultation with the client.

b. Time spent with clients shall be rounded to the quarter hour.

78.24(2) Payment will be approved for the following psychological procedures:

a. Individual outpatient psychotherapy or other psychological procedures not to exceed one hour per week or 40 hours in any 12-month period, or

b. Couple, marital, family, or group outpatient therapy not to exceed one and one-half hours per week or 60 hours in any 12-month period, or

c. A combination of individual and group therapy not to exceed the cost of 40 individual therapy hours in any 12-month period.

d. Psychological examinations and testing for purposes of evaluation, placement, psychotherapy, or assessment of therapeutic progress, not to exceed eight hours in any 12-month period.

e. Mileage at the same rate as in 78.1(8) when the following conditions are met:

(1) It is necessary for the psychologist to travel outside of the home community, and

(2) There is no qualified mental health professional more immediately available in the community, and

(3) The member has a medical condition which prohibits travel.

f. Covered procedures necessary to maintain continuity of psychological treatment during periods of hospitalization or convalescence for physical illness.

g. Procedures provided within a licensed hospital, residential treatment facility, day hospital, or nursing home as part of an approved treatment plan and a psychologist is not employed by the facility.

78.24(3) Payment will not be approved for the following services:

a. Psychological examinations performed without relationship to evaluations or psychotherapy for a specific condition, symptom, or complaint.

b. Psychological examinations covered under Part B of Medicare, except for the Part B Medicare deductible and coinsurance.

c. Psychological examinations employing unusual or experimental instrumentation.

d. Individual and group psychotherapy without specification of condition, symptom, or complaint.

e. Sensitivity training, marriage enrichment, assertiveness training, growth groups or marathons, or psychotherapy for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

78.24(4) Rescinded IAB 10/12/94, effective 12/1/94.

78.24(5) The following services shall require review by a consultant to the department.

a. Protracted therapy beyond 16 visits. These cases shall be reviewed following the sixteenth therapy session and periodically thereafter.

b. Any service which does not appear necessary or appears to fall outside the scope of what is professionally appropriate or necessary for a particular condition.

This rule is intended to implement Iowa Code sections 249A.4 and 249A.15.

441—78.25(249A) Maternal health centers. Payment will be made for prenatal and postpartum medical care, health education, and transportation to receive prenatal and postpartum services. Payment

will be made for enhanced perinatal services for persons determined high risk. These services include additional health education services, nutrition counseling, social services, and one postpartum home visit. Maternal health centers shall provide trimester and postpartum reports to the referring physician. Risk assessment using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.25(1) *Provider qualifications.*

a. Prenatal and postpartum medical services shall be provided by a physician, a physician assistant, or a nurse practitioner employed by or on contract with the center. Medical services performed by maternal health centers shall be performed under the supervision of a physician. Nurse practitioners and physician assistants performing under the supervision of a physician must do so within the scope of practice of that profession, as defined by Iowa Code chapters 152 and 148C, respectively.

b. Rescinded IAB 12/3/08, effective 2/1/09.

c. Education services and postpartum home visits shall be provided by a registered nurse.

d. Nutrition services shall be provided by a licensed dietitian.

e. Psychosocial services shall be provided by a person with at least a bachelor's degree in social work, counseling, sociology, psychology, family and community services, health or human development, health education, or individual and family studies.

78.25(2) *Services covered for all pregnant women.* Services provided may include:

a. Prenatal and postpartum medical care.

b. Health education, which shall include:

(1) Importance of continued prenatal care.

(2) Normal changes of pregnancy including both maternal changes and fetal changes.

(3) Self-care during pregnancy.

(4) Comfort measures during pregnancy.

(5) Danger signs during pregnancy.

(6) Labor and delivery including the normal process of labor, signs of labor, coping skills, danger signs, and management of labor.

(7) Preparation for baby including feeding, equipment, and clothing.

(8) Education on the use of over-the-counter drugs.

(9) Education about HIV protection.

c. Home visit.

d. Transportation to receive prenatal and postpartum services that is not payable under rule 441—78.11(249A) or 441—78.13(249A).

e. Dental hygiene services within the scope of practice as defined by the dental board at 650—paragraph 10.5(3)*"b."*

78.25(3) *Enhanced services covered for women with high-risk pregnancies.* Enhanced perinatal services may be provided to a patient who has been determined to have a high-risk pregnancy as documented by Form 470-2942, Medicaid Prenatal Risk Assessment. An appropriately trained physician or advanced registered nurse practitioner must be involved in staffing the patients receiving enhanced services.

Enhanced services are as follows:

a. Rescinded IAB 12/3/08, effective 2/1/09.

b. Education, which shall include as appropriate education about the following:

(1) High-risk medical conditions.

(2) High-risk sexual behavior.

(3) Smoking cessation.

(4) Alcohol usage education.

(5) Drug usage education.

(6) Environmental and occupational hazards.

c. Nutrition assessment and counseling, which shall include:

(1) Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.

(2) Ongoing nutritional assessment.

(3) Development of an individualized nutritional care plan.

(4) Referral to food assistance programs if indicated.

(5) Nutritional intervention.

d. Psychosocial assessment and counseling, which shall include:

(1) A psychosocial assessment including: needs assessment, profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.

(2) A profile of the client's family composition, patterns of functioning and support systems.

(3) An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

e. A postpartum home visit within two weeks of the child's discharge from the hospital, which shall include:

(1) Assessment of mother's health status.

(2) Physical and emotional changes postpartum.

(3) Family planning.

(4) Parenting skills.

(5) Assessment of infant health.

(6) Infant care.

(7) Grief support for unhealthy outcome.

(8) Parenting of a preterm infant.

(9) Identification of and referral to community resources as needed.

78.25(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a maternal health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.26(249A) Ambulatory surgical center services. Ambulatory surgical center services are those services furnished by an ambulatory surgical center in connection with a covered surgical procedure or a covered dental procedure. Covered procedures are listed in the fee schedule published on the department's Web site.

78.26(1) Covered surgical procedures shall be those medically necessary procedures that are eligible for payment as physicians' services, under the circumstances specified in rule 441—78.1(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(2) Covered dental procedures are those medically necessary procedures that are eligible for payment as dentists' services, under the circumstances specified in rule 441—78.4(249A) and performed on a Medicaid member, that can safely be performed in an outpatient setting for Medicaid members whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

78.26(3) The covered services provided by the ambulatory surgical center in connection with a Medicaid-covered surgical or dental procedure shall be those nonsurgical and nondental services that:

a. Are medically necessary in connection with a Medicaid-covered surgical or dental procedure;

b. Are eligible for payment as physicians' services under the circumstances specified in rule 441—78.1(249A) or as dentists' services under the circumstances specified in rule 441—78.4(249A); and

c. Can safely and economically be performed in an outpatient setting, as determined by the department upon advice from the Iowa Medicaid enterprise medical services unit.

78.26(4) Limits on covered services.

a. Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

b. Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

c. Preprocedure review by the IME medical services unit is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from the IME medical services unit. (Cross reference 78.28(6))

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

[**ARC 8205B**, IAB 10/7/09, effective 11/11/09; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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

78.27(1) *Definitions.*

"Adult" means a person who is 18 years of age or older.

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Benefits education" means providing basic information to understand and access appropriate resources to pursue employment, and knowledge of work incentives and the Medicaid for employed persons with disabilities (MEPD) program. Benefits education may include gathering information needed to pursue work incentives and offering basic financial management information to members, families, guardians and legal representatives.

"Care coordinator" means the professional who assists members in care coordination as described in paragraph 78.53(1)*"b."*

"Career exploration," also referred to as "career planning," means a person-centered, comprehensive employment planning and support service that provides assistance for waiver program participants to obtain, maintain or advance in competitive employment or self-employment. Career exploration is a focused, time-limited service engaging a participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state's minimum wage. The outcome of this service is documentation of the participant's stated career objective and a career plan used to guide individual employment support.

"Career plan" means a written plan documenting the member's stated career objective and used to guide individual employment support services for achieving competitive, integrated employment at or above the state's minimum wage.

"Case management" means case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90.

"Comprehensive service plan" means an individualized, goal-oriented plan of services written in language understandable by the member using the service and developed collaboratively by the member and the case manager.

"Customized employment" means an approach to supported employment which individualizes the employment relationship between employees and employers in ways that meet the needs of both. Customized employment is based on an individualized determination of the strengths, needs, and interests of the person with a disability and is also designed to meet the specific needs of the employer. Customized employment may include employment developed through job carving, self-employment or entrepreneurial initiatives, or other job development or restructuring strategies that result in job responsibilities being customized and individually negotiated to fit the needs of the individual with a disability. Customized employment assumes the provision of reasonable accommodations and supports necessary for the individual to perform the functions of a job that is individually negotiated and developed.

"Department" means the Iowa department of human services.

"Emergency" means a situation for which no approved individual program plan exists that, if not addressed, may result in injury or harm to the member or to other persons or in significant amounts of property damage.

"HCBS" means home- and community-based services.

"Individual employment" means employment in the general workforce where the member interacts with the general public to the same degree as nondisabled persons in the same job, and for which the member is paid at or above minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by persons without disabilities.

"Individual placement and support" means an evidence-based supported employment model that helps people with mental illness to seek and obtain employment.

"Integrated community employment" means work (including self-employment) for which an individual with a disability is paid at or above minimum wage and not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by employees who are not disabled, where the individual interacts with other persons who are not disabled to the same extent as others who are in comparable positions, and which presents opportunities for advancement that are similar to those for employees who are not disabled. In the case of an individual who is self-employed, the business results in an income that is comparable to the income received by others who are not disabled and are self-employed in similar occupations.

"Integrated health home" means the provision of services to enrolled members as described in subrule 78.53(1).

"Interdisciplinary team" means a group of persons with varied professional backgrounds who meet with the member to develop a comprehensive service plan to address the member's need for services.

"ISIS" means the department's individualized services information system.

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

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for qualifying members.

"Supported employment" means the ongoing supports to participants who, because of their disabilities, need intensive ongoing support to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce at or above the state's minimum wage or at or above the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of this service is sustained paid employment at or above the minimum wage in an integrated setting in the general workforce in a job that meets personal and career goals. Supported employment services can be provided through many different service models.

"Supported self-employment" includes services and supports that assist the participant in achieving self-employment through the operation of a business; however, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Assistance for self-employment may include aid to the individual in identifying potential business opportunities; assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; identification of the supports necessary for the individual to operate the business; and ongoing assistance, counseling and guidance once the business has been launched.

"Sustained employment" means an individual employment situation that the member maintains over time but not for less than 90 calendar days following the receipt of employment services and supports.

78.27(2) *Member eligibility.* To be eligible to receive home- and community-based habilitation services, a member shall meet the following criteria:

a. *Risk factors.* The member has at least one of the following risk factors:

(1) The member has undergone or is currently undergoing psychiatric treatment more intensive than outpatient care (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization) more than once in the member's life; or

(2) The member has a history of psychiatric illness resulting in at least one episode of continuous, professional supportive care other than hospitalization.

b. Need for assistance. The member has a need for assistance demonstrated by meeting at least two of the following criteria on a continuing or intermittent basis for at least two years:

(1) The member is unemployed, is employed in a sheltered setting, or has markedly limited skills and a poor work history.

(2) The member requires financial assistance for out-of-hospital maintenance and is unable to procure this assistance without help.

(3) The member shows severe inability to establish or maintain a personal social support system.

(4) The member requires help in basic living skills such as self-care, money management, housekeeping, cooking, and medication management.

(5) The member exhibits inappropriate social behavior that results in a demand for intervention.

c. Income. The countable income used in determining the member's Medicaid eligibility does not exceed 150 percent of the federal poverty level.

d. Needs assessment. The interRAI - Child and Youth Mental Health (ChYMH) for youth aged 16 to 18 or the interRAI - Community Mental Health (CMH) for those aged 19 and older has been completed, and based on information submitted on the information submission tool and other supporting documentation as relevant, the IME medical services unit has determined that the member is in need of home- and community-based habilitation services. The interRAI - Child and Youth Mental Health (ChYMH) and the interRAI - Community Mental Health (CMH) information submission tools are available on request from the IME medical services unit. Copies of the information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator, or managed care organization. The designated case manager or integrated health home care coordinator shall:

(1) Arrange for the completion of the interRAI, before services begin and annually thereafter.

(2) Use the information submission tool and other supporting documentation as relevant to develop a comprehensive service plan as specified in subrule 78.27(4), before services begin and annually thereafter.

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

(1) The member's comprehensive service plan shall be completed annually according to the requirements of subrule 78.27(4). A service plan may change at any time due to a significant change in the member's needs.

(2) The member's habilitation services shall not exceed the maximum number of units established for each service in 441—subrule 79.1(2).

(3) The cost of the habilitation services shall not exceed unit expense maximums established in 441—subrule 79.1(2).

78.27(3) *Application for services.* The member, case manager or integrated health home care coordinator shall apply for habilitation services on behalf of a member by contacting the IME medical services unit. The department shall issue a notice of decision to the applicant when financial eligibility and needs-based eligibility determinations have been completed.

78.27(4) *Comprehensive service plan.* Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service plan or treatment plan developed with the member in collaboration with an interdisciplinary team, as appropriate. Medically necessary services shall be planned for and provided at the locations where the member lives, learns, works, and socializes.

a. Development. A comprehensive service plan or treatment plan shall be developed for each member receiving home- and community-based habilitation services based on the member's current assessment and shall be reviewed on an annual basis.

(1) The case manager or the integrated health home care coordinator shall establish an interdisciplinary team for the member. The team shall include the case manager or integrated health

home care coordinator and the member and, if applicable, the member's legal representative, the member's family, the member's service providers, and others directly involved.

(2) With the interdisciplinary team, the case manager or integrated health home care coordinator shall identify the member's services based on the member's needs, the availability of services, and the member's choice of services and providers.

(3) The comprehensive service plan development shall be completed at the member's home or at another location chosen by the member.

(4) The interdisciplinary team meeting shall be conducted before the current comprehensive service plan expires.

(5) The comprehensive service plan shall reflect desired individual outcomes.

(6) Services defined in the comprehensive service plan shall be appropriate to the severity of the member's problems and to the member's specific needs or disabilities.

(7) Activities identified in the comprehensive service plan shall encourage the ability and right of the member to make choices, to experience a sense of achievement, and to modify or continue participation in the treatment process.

(8) For members receiving home-based habilitation in a licensed residential care facility of 16 or fewer beds, the service plan shall address the member's opportunities for independence and community integration.

(9) The initial comprehensive service plan or treatment plan and annual updates to the comprehensive service plan or treatment plan must be approved by the IME medical services unit in ISIS before services are implemented. Services provided before the approval date are not payable. The written comprehensive service plan or treatment plan must be completed, signed and dated by the case manager, integrated health home care coordinator, or service worker within 30 calendar days after plan approval.

(10) Any changes to the comprehensive service plan or treatment plan must be approved by the IME medical services unit for members not eligible to enroll in a managed care organization in ISIS before the implementation of services. Services provided before the approval date are not payable.

b. *Service goals and activities.* The comprehensive service plan shall:

(1) Identify observable or measurable individual goals.

(2) Identify interventions and supports needed to meet those goals with incremental action steps, as appropriate.

(3) Identify the staff persons, businesses, or organizations responsible for carrying out the interventions or supports.

(4) List all Medicaid and non-Medicaid services received by the member and identify:

1. The name of the provider responsible for delivering the service;
2. The funding source for the service; and
3. The number of units of service to be received by the member.

(5) Identify for a member receiving home-based habilitation:

1. The member's living environment at the time of enrollment;
2. The number of hours per day of on-site staff supervision needed by the member; and
3. The number of other members who will live with the member in the living unit.

(6) Include a separate, individualized, anticipated discharge plan that is specific to each service the member receives.

c. *Rights restrictions.* Any rights restrictions must be implemented in accordance with 441—subrule 77.25(4). The comprehensive service plan or treatment plan shall include documentation of:

(1) Any restrictions on the member's rights, including maintenance of personal funds and self-administration of medications;

(2) The need for the restriction; and

(3) Either a plan to restore those rights or written documentation that a plan is not necessary or appropriate.

d. *Emergency plan.* The comprehensive service plan or treatment plan shall include a plan for emergencies and identification of the supports available to the member in an emergency. Emergency plans shall be developed as follows:

(1) The member's interdisciplinary team shall identify in the comprehensive service plan or treatment plan any health and safety issues applicable to the individual member based on information gathered before the team meeting, including a risk assessment.

(2) The interdisciplinary team shall identify an emergency backup support and crisis response system to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(3) Providers of applicable services shall provide for emergency backup staff.

e. *Plan approval.* Services shall be entered into ISIS based on the comprehensive service plan. A comprehensive service plan or treatment plan that has been validated and authorized through ISIS shall be considered approved by the department. Services must be authorized in ISIS as specified in paragraph 78.27(2)*"e."*

78.27(5) *Requirements for services.* Home- and community-based habilitation services shall be provided in accordance with the following requirements:

a. The services shall be based on the member's needs as identified in the member's comprehensive service plan.

b. The services shall be delivered in the least restrictive environment appropriate to the needs of the member.

c. The services shall include the applicable and necessary instruction, supervision, assistance, and support required by the member to achieve the member's life goals.

d. Service components that are the same or similar shall not be provided simultaneously.

e. Service costs are not reimbursable while the member is in a medical institution, including but not limited to a hospital or nursing facility.

f. Reimbursement is not available for room and board.

g. Services shall be billed in whole units.

h. Services shall be documented. Each unit billed must have corresponding financial and medical records as set forth in rule 441—79.3(249A).

78.27(6) *Case management.* Case management assists members in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. *Scope.* Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. *Exclusions.*

(1) Payment shall not be made for case management provided to a member who is enrolled for integrated health home services under rule 441—78.53(249A) except during the transition to the integrated health homes.

(2) Payment shall not be made for case management provided to a member who is eligible for case management services under 441—Chapter 90.

78.27(7) *Home-based habilitation.* "Home-based habilitation" means individually tailored supports that assist with the acquisition, retention, or improvement of skills related to living in the community.

a. *Scope.* Home-based habilitation services are individualized supportive services provided in the member's home and community that assist the member to reside in the most integrated setting appropriate to the member's needs. Services are intended to provide for the daily living needs of the member and shall be available as needed during any 24-hour period. The specific support needs for each member shall be determined necessary by the interdisciplinary team and shall be identified in the member's comprehensive service plan. Covered supports include:

(1) Adaptive skill development;

(2) Assistance with activities of daily living;

(3) Community inclusion;

(4) Transportation;

(5) Adult educational supports;
(6) Social and leisure skill development;
(7) Personal care; and
(8) Protective oversight and supervision.

b. *Exclusions.* Home-based habilitation payment shall not be made for the following:

(1) Room and board and maintenance costs, including the cost of rent or mortgage, utilities, telephone, food, household supplies, and building maintenance, upkeep, or improvement.

(2) Service activities associated with vocational services, day care, medical services, or case management.

(3) Transportation to and from a day program.

(4) Services provided to a member who lives in a licensed residential care facility of more than 16 persons.

(5) Services provided to a member who lives in a facility that provides the same service as part of an inclusive or "bundled" service rate, such as a nursing facility or an intermediate care facility for persons with mental retardation.

(6) Personal care and protective oversight and supervision may be a component part of home-based habilitation services but may not comprise the entirety of the service.

78.27(8) *Day habilitation.* "Day habilitation" means assistance with acquisition, retention, or improvement of self-help, socialization, and adaptive skills.

a. *Scope.* Day habilitation activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services focus on enabling the member to attain or maintain the member's maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the comprehensive service plan. Services may serve to reinforce skills or lessons taught in other settings. Services must enhance or support the member's:

(1) Intellectual functioning;
(2) Physical and emotional health and development;
(3) Language and communication development;
(4) Cognitive functioning;
(5) Socialization and community integration;
(6) Functional skill development;
(7) Behavior management;
(8) Responsibility and self-direction;
(9) Daily living activities;
(10) Self-advocacy skills; or
(11) Mobility.

b. *Setting.* Day habilitation shall take place in a nonresidential setting separate from the member's residence. Services shall not be provided in the member's home. When the member lives in a residential care facility of more than 16 beds, day habilitation services provided in the facility are not considered to be provided in the member's home if the services are provided in an area apart from the member's sleeping accommodations.

c. *Duration.* Day habilitation services shall be furnished for four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the member's comprehensive service plan. Meals provided as part of day habilitation shall not constitute a full nutritional regimen (three meals per day).

d. *Exclusions.* Day habilitation payment shall not be made for the following:

(1) Vocational or prevocational services.

(2) Services that duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(3) Compensation to members for participating in day habilitation services.

78.27(9) *Prevocational service habilitation.* "Prevocational services" means services that provide career exploration, learning and work experiences, including volunteer opportunities, where the member

can develop non-job-task-specific strengths and skills that lead to paid employment in individual community settings.

a. Scope. Prevocational services are provided to persons who are expected to be able to join the general workforce with the assistance of supported employment. Prevocational services are intended to develop and teach general employability skills relevant to successful participation in individual employment. These skills include but are not limited to the ability to communicate effectively with supervisors, coworkers and customers; an understanding of generally accepted community workplace conduct and dress; the ability to follow directions; the ability to attend to tasks; workplace problem-solving skills and strategies; general workplace safety and mobility training; the ability to navigate local transportation options; financial literacy skills; and skills related to obtaining employment.

Prevocational services include career exploration activities to facilitate successful transition to individual employment in the community. Participation in prevocational services is not a prerequisite for individual or small-group supported employment services.

(1) Career exploration. Career exploration activities are designed to develop an individual career plan and facilitate the member's experientially based informed choice regarding the goal of individual employment. Career exploration may be provided in small groups of no more than four members to participate in career exploration activities that include business tours, attending industry education events, benefit information, financial literacy classes, and attending career fairs. Career exploration may be authorized for up to 34 hours, to be completed over 90 days in the member's local community or nearby communities and may include but is not limited to the following activities:

1. Meeting with the member and the member's family, guardian or legal representative to introduce them to supported employment and explore the member's employment goals and experiences,
2. Business tours,
3. Informational interviews,
4. Job shadows,
5. Benefits education and financial literacy,
6. Assistive technology assessment, and
7. Job exploration events.

(2) Expected outcome of service.

1. The expected outcome of prevocational services is individual employment in the general workforce, or self-employment, in a setting typically found in the community, where the member interacts with individuals without disabilities, other than those providing services to the member or other individuals with disabilities, to the same extent that individuals without disabilities in comparable positions interact with other persons; and for which the member is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

2. The expected outcome of the career exploration activity is a written career plan that will guide employment services which lead to community employment or self-employment for the member.

b. Setting. Prevocational services shall take place in community-based nonresidential settings.

c. Concurrent services. A member's individual service plan may include two or more types of nonresidential habilitation services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

d. Exclusions. Prevocational services payment shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that funding is not available to the individual for the service under these programs shall be maintained in the service plan of each member receiving prevocational services.

(2) Services available to the individual that duplicate or replace education or related services defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

(3) Compensation to members for participating in prevocational services.

(4) Support for members volunteering in for-profit organizations and businesses other than for-profit organizations, or businesses that have formal volunteer programs in place (e.g., hospitals, nursing homes), and support for members volunteering to benefit the service provider.

(5) The provision of vocational services delivered in facility-based settings where individuals are supervised for the primary purpose of producing goods or performing services or where services are aimed at teaching skills for specific types of jobs rather than general skills.

(6) A prevocational service plan with the goal or purpose of the service documented as maintaining or supporting the individual in continuing prevocational services or any employment situation similar to sheltered employment.

e. Limitations.

(1) Time limitation for members starting prevocational services. For members starting prevocational services after May 4, 2016, participation in these services is limited to 24 calendar months. This time limit can be extended to continue beyond 24 months if one or more of the following conditions apply:

1. The member who is in prevocational services is also working in either individual or small-group community employment for at least the number of hours per week desired by the member, as identified in the member's current service plan; or

2. The member who is in prevocational services is also working in either individual or small-group community employment for less than the number of hours per week the member desires, as identified in the member's current service plan, but the member has services documented in the member's current service plan, or through another identifiable funding source (e.g., Iowa vocational rehabilitation services (IVRS)), to increase the number of hours the member is working in either individual or small-group community employment; or

3. The member is actively engaged in seeking individual or small-group community employment or individual self-employment, and services for this are included in the member's current service plan or services funded through another identifiable funding source (e.g., IVRS) are documented in the member's service plan; or

4. The member has requested supported employment services from Medicaid and IVRS in the past 24 months, and the member's request has been denied or the member has been placed on a waiting list by both Medicaid and IVRS; or

5. The member has been receiving individual supported employment services (or comparable services available through IVRS) for at least 18 months without obtaining individual or small-group community employment or individual self-employment; or

6. The member is participating in career exploration activities as described in subparagraph 78.27(9)*"a"*(1).

(2) Time limitation for members enrolled in prevocational services. For members enrolled in prevocational services on or before May 4, 2016, participation in these services is limited to 90 business days beyond the completion of the career exploration activity including the development of the career plan described in subparagraph 78.27(9)*"a"*(1). This time limit can be extended as stated in paragraphs 78.27(9)*"e"*(1)"1" through "6." If the criteria in paragraphs 78.27(9)*"e"*(1)"1" through "6" do not apply, the member will not be reauthorized to continue prevocational services.

78.27(10) *Supported employment services.*

a. Individual supported employment. Individual supported employment involves supports provided to, or on behalf of, the member that enable the member to obtain and maintain individual employment. Services are provided to members who need support because of their disabilities.

(1) Scope. Individual supported employment services are services provided to, or on behalf of, the member that enable the member to obtain and maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(2) Expected outcome of service. The expected outcome of this service is sustained employment, or self-employment, paid at or above the minimum wage or the customary wage and level of benefits paid by an employer, in an integrated setting in the general workforce, in a job that meets personal and career goals. Successful transition to long-term job coaching, if needed, is also an expected outcome of

this service. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Individual supported employment services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting where members are paid for the production of goods or services) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities or with the general public.

(4) Individual employment strategies include but are not limited to: customized employment, individual placement and support, and supported self-employment. Service activities are individualized and may include any combination of the following:

1. Benefits education.
2. Career exploration (e.g., tours, informational interviews, job shadows).
3. Employment assessment.
4. Assistive technology assessment.
5. Trial work experience.
6. Person-centered employment planning.
7. Development of visual/traditional résumés.
8. Job-seeking skills training and support.
9. Outreach to prospective employers on behalf of the member (e.g., job development; negotiation with prospective employers to customize, create or carve out a position for the member; employer needs analysis).
10. Job analysis (e.g., work site assessment or job accommodations evaluation).
11. Identifying and arranging transportation.
12. Career advancement services (e.g., assisting a member in making an upward career move or seeking promotion from an existing employer).
13. Reemployment services (if necessary due to job loss).
14. Financial literacy and asset development.
15. Other employment support services deemed necessary to enable the member to obtain employment.
16. Systematic instruction and support during initial on-the-job training including initial on-the-job training to stabilization.
17. Engagement of natural supports during initial period of employment.
18. Implementation of assistive technology solutions during initial period of employment.
19. Transportation of the member during service hours.
20. Initial on-the-job training to stabilization activity.

(5) Self-employment. Individual employment may also include support to establish a viable self-employment opportunity, including home-based self-employment. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. In addition to the activities listed under subparagraph 78.27(10)*"a"*(4), assistance to establish self-employment may include:

1. Aid to the member in identifying potential business opportunities.
2. Assistance in the development of a business plan, including identifying potential sources of business financing and other assistance in developing and launching a business.
3. Identification of the long-term supports necessary for the individual to operate the business.

b. Long-term job coaching. Long-term job coaching is support provided to, or on behalf of, the member that enables the member to maintain an individual job in competitive employment, customized employment or self-employment in an integrated work setting in the general workforce.

(1) Scope. Long-term job coaching services are provided to or on behalf of members who need support because of their disabilities and who are unlikely to maintain and advance in individual employment absent the provision of supports. Long-term job coaching services shall provide

individualized and ongoing support contacts at intervals necessary to promote successful job retention and advancement.

(2) Expected outcome of service. The expected outcome of this service is sustained employment paid at or above the minimum wage in an integrated setting in the general workforce, in a job that meets the member's personal and career goals. An expected outcome of supported self-employment is that the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time.

(3) Setting. Long-term job coaching services shall take place in integrated work settings. For self-employment, the member's home can be considered an integrated work setting. Employment in the service provider's organization (not including a sheltered workshop or similar type of work setting) can be considered employment in an integrated work setting in the general workforce if the employment occurs in a work setting where interactions are predominantly with coworkers or business associates who do not have disabilities, or with the general public, and if the position would exist within the provider's organization were the provider not being paid to provide the job coaching to the member.

(4) Service activities. Long-term job coaching services are designed to assist the member with learning and retaining individual employment, resulting in workplace integration, and which allows for the reduction of long-term job coaching over time. Services are individualized, and service plans are adjusted as support needs change and may include any combination of the following activities with or on behalf of the member:

1. Job analysis.
2. Job training and systematic instruction.
3. Training and support for use of assistive technology/adaptive aids.
4. Engagement of natural supports.
5. Transportation coordination.
6. Job retention training and support.
7. Benefits education and ongoing support.
8. Supports for career advancement.
9. Financial literacy and asset development.
10. Employer consultation and support.
11. Negotiation with employer on behalf of the member (e.g., accommodations; employment conditions; access to natural supports; and wage and benefits).
12. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the job setting.
13. Transportation of the member during service hours.
14. Career exploration services leading to increased hours or career advancement.

(5) Self-employment long-term job coaching. Self-employment long-term job coaching may include support to maintain a self-employment opportunity, including home-based self-employment. In addition to the activities listed under subparagraph 78.27(10)*"b"*(4), assistance to maintain self-employment may include:

1. Ongoing identification of the supports necessary for the individual to operate the business;
2. Ongoing assistance, counseling and guidance to maintain and grow the business; and
3. Ongoing benefits education and support.

(6) The hours of support for long-term job coaching are based on the identified needs of the member as documented in the member's comprehensive service plan.

c. Small-group supported employment. Small-group supported employment services are training and support activities provided in regular business or industry settings for groups of two to eight workers with disabilities. The outcome of this service is sustained paid employment experience, skill development, career exploration and planning leading to referral for services to obtain individual integrated employment or self-employment for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

(1) Scope. Small-group supported employment services must be provided in a manner that promotes integration into the workplace and interaction between members and people without disabilities (e.g., customers, coworkers, natural supports) in those workplaces. Examples include but are not limited to mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in integrated business settings; and small-group activities focused on career exploration and development of strengths and skills that contribute to successful participation in individual community employment.

(2) Expected outcome of service. Small-group supported employment services are expected to enable the member to make reasonable and continued progress toward individual employment. Participation in small-group supported employment services is not a prerequisite for individual supported employment services. The expected outcome of the service is sustained paid employment and skill development which leads to individual employment in the community.

(3) Setting. Small-group supported employment services shall take place in integrated, community-based nonresidential settings separate from the member's residence.

(4) Service activities. Small-group supported employment services may include any combination of the following activities:

1. Employment assessment.
2. Person-centered employment planning.
3. Job placement (limited to service necessary to facilitate hire into individual employment paid at minimum wage or higher for a member in small-group supported employment who receives an otherwise unsolicited offer of a job from a business where the member has been working in a mobile crew or enclave).
4. Job analysis.
5. On-the-job training and systematic instruction.
6. Job coaching.
7. Transportation planning and training.
8. Benefits education.
9. Career exploration services leading to career advancement outcomes.
10. Other workplace support services may include services not specifically related to job skill training that enable the waiver member to be successful in integrating into the individual or community setting.
11. Transportation of the member during service hours.

d. Service requirements for all supported employment services.

(1) Community transportation options (e.g., transportation provided by family, coworkers, carpools, volunteers, self or public transportation) shall be identified by the member's interdisciplinary team and utilized before the service provider provides the transportation to and from work for the member. If none of these options are available to a member, transportation between the member's place of residence and the employment or service location may be included as a component part of supported employment services.

(2) Personal care or personal assistance and protective oversight may be a component part of supported employment services, but may not comprise the entirety of the service.

(3) Activities performed on behalf of a member receiving long-term job coaching or individual or small-group supported employment shall not comprise the entirety of the service.

(4) Concurrent services. A member's individual service plan may include two or more types of nonresidential services (e.g., individual supported employment, long-term job coaching, small-group supported employment, prevocational services, and day habilitation); however, more than one service may not be billed during the same period of time (e.g., the same hour).

(5) Integration requirements. In the performance of job duties, the member shall have regular contact with other employees or members of the general public who do not have disabilities, unless the absence of regular contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(6) Compensation. Members receiving these services are compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. For supported self-employment, the member earns income that is equal to or exceeds the average income for the chosen business within a reasonable period of time. For small-group supported employment, if the member is not compensated at or above minimum wage, the compensation to the member shall be in accordance with all applicable state and federal labor laws and regulations.

e. *Limitations.* Supported employment services are limited as follows:

(1) Total monthly costs of supported employment may not exceed the monthly cap on the cost of waiver services set for the individual waiver program.

(2) In absence of a monthly cap on the cost of waiver services, the total monthly cost of all supported employment services may not exceed $3,059.29 per month.

(3) Individual supported employment is limited to 240 units per calendar year.

(4) Long-term job coaching is limited in accordance with 441—subrule 79.1(2).

(5) Small-group supported employment is limited to 160 units per week.

f. *Exclusions.* Supported employment services payments shall not be made for the following:

(1) Services that are available to the individual under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Documentation that the service is not available to the individual under these programs shall be maintained in the service plan of each member receiving individual supported employment or long-term job coaching services.

(2) Incentive payments, not including payments for coworker supports, made to an employer to encourage or subsidize the employer's participation in a supported employment program.

(3) Subsidies or payments that are passed through to users of supported employment programs.

(4) Training that is not directly related to a member's supported employment program.

(5) Services involved in placing and stabilizing members in day activity programs, work activity programs, sheltered workshop programs or other similar types of vocational or prevocational services furnished in specialized facilities that are not a part of the general workplace.

(6) Supports for placement and stabilization in volunteer positions or unpaid internships. Such volunteer learning and unpaid training activities that prepare a person for entry into the general workforce are addressed through prevocational services and career exploration activities.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not related to integrated individual employment participation or is not member-specific.

(9) Medicaid funds may not be used to defray the expenses associated with starting up or operating a business.

78.27(11) *Adverse service actions.*

a. *Denial.* Services shall be denied when the department determines that:

(1) The member is not eligible for or in need of home- and community-based habilitation services.

(2) The service is not identified in the member's comprehensive service plan or treatment plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(5) Completion or receipt of required documents for the program has not occurred.

b. *Reduction.* A particular home- and community-based habilitation service may be reduced when the department determines that continued provision of service at its current level is not necessary.

c. *Termination.* A particular home- and community-based habilitation service may be terminated when the department determines that:

(1) The member's income exceeds the allowable limit, or the member no longer meets other eligibility criteria for the program established by the department.

(2) The service is not identified in the member's comprehensive service plan.

(3) Needed services are not available or received from qualifying providers, or no qualifying providers are available.

(4) The member's service needs are not being met by the services provided.

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

(6) The member's service needs exceed the unit or reimbursement maximums for a service as established by the department.

(7) Duplication of services provided during the same period has occurred.

(8) The member or the member's legal representative, through the interdisciplinary process, requests termination of the service.

(9) Completion or receipt of required documents for the program has not occurred, or the member refuses to allow documentation of eligibility as to need and income.

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

78.27(12) *County reimbursement.* Rescinded IAB 7/11/12, effective 7/1/12.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09 (See Delay note at end of chapter); **ARC 9311B**, IAB 12/29/10, effective 1/1/11; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—78.28(249A) List of medical services and equipment requiring prior authorization, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician, physician assistant, or advanced registered nurse practitioner which are subject to prior authorization or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A:

a. Drugs require prior authorization as specified in the preferred drug list published by the department pursuant to Iowa Code section 249A.20A. For drugs requiring prior authorization, reimbursement will be made for a 72-hour supply dispensed in an emergency when a prior authorization request cannot be submitted.

b. Automated medication dispenser. Payment shall be approved pursuant to the criteria at 78.10(5)*"d."*

c. Enteral products and enteral delivery pumps and supplies. Payment shall be approved pursuant to the criteria at 78.10(5)*"l."*

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Speech generating device. Payment shall be approved pursuant to the criteria at 78.10(5)*"f."*

f. Preprocedure review by the IME medical services unit will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and on the criteria established by the department and the IME medical services unit. If not so approved by the IME medical services unit, payment will not

be made under the program to the physician or to the facility in which the surgery is performed. The criteria are available from the IME medical services unit.

g. Enclosed beds. Payment shall be approved pursuant to the criteria at 78.10(5)*"a."*

h. Prior authorization is required for external insulin infusion pumps and is granted according to Medicare coverage criteria. (Cross reference 78.10(2)*"c"*)

i. Oral nutritional products. Payment shall be approved pursuant to the criteria at 78.10(5)*"m."*

j. Vest airway clearance system. Payment shall be approved pursuant to the criteria at 78.10(5)*"c."*

k. Diabetic equipment and supplies. Payment will be approved pursuant to the criteria at 78.10(5)*"e."*

l. Reimbursement over the established Medicaid fee schedule amount. Payment shall be approved pursuant to the criteria at 78.10(5)*"n."*

m. Bathtub/shower chair, bench. Payment shall be approved pursuant to the criteria at 78.10(5)*"g."*

n. Patient lift, nonstandard. Payment shall be approved pursuant to the criteria at 78.10(5)*"h."*

o. Power wheelchair attendant control. Payment shall be approved pursuant to the criteria at 78.10(5)*"i."*

p. Shower commode chair. Payment shall be approved pursuant to the criteria at 78.10(5)*"j."*

q. Ventilator, secondary. Payment shall be approved pursuant to the Medicare coverage criteria.

r. Customized wheelchairs for members who are residents of nursing facilities, subject to the requirements of 78.10(2)*"a"*(4).

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Periodontal scaling and root planing. Payment will be approved pursuant to the criteria at 78.4(4)*"b."*

(2) Pedicle soft tissue graft, free soft tissue graft, and subepithelial tissue graft. Payment will be approved pursuant to the criteria at 78.4(4)*"d."*

(3) Periodontal maintenance therapy. Payment will be approved pursuant to the criteria at 78.4(4)*"e."*

(4) Tissue regeneration. Payment will be approved pursuant to the criteria at 78.4(4)*"f."*

(5) Localized delivery of antimicrobial agents. Payment will be approved pursuant to the criteria at 78.4(4)*"g."*

b. The following prosthetic services:

(1) A removable partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"b."*

(2) A fixed partial denture replacing anterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"d."*

(3) A removable partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"c."*

(4) A fixed partial denture replacing posterior teeth. Payment will be approved pursuant to the criteria at 78.4(7)*"e."*

(5) Dental implants and related services. Payment will be approved pursuant to the criteria at 78.4(7)*"k."*

(6) Replacement of complete or partial dentures in less than a five-year period. Payment will be approved pursuant to the criteria at 78.4(7)*"l."*

(7) A complete or partial denture rebase. Payment will be approved pursuant to the criteria at 78.4(7)*"m."*

(8) An oral appliance for obstructive sleep apnea. Payment will be approved pursuant to the criteria at 78.4(7)*"n."*

c. The following orthodontic services:

(1) Minor treatment to control harmful habits. Payment will be approved pursuant to the criteria at 78.4(8)*"a."*

(2) Interceptive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)*"b."*

(3) Comprehensive orthodontic treatment. Payment will be approved pursuant to the criteria at 78.4(8)*"c."*

d. The following restorative services:

(1) Laboratory-fabricated crowns other than stainless steel. Payment will be approved pursuant to the criteria at 78.4(3)*"d"*(3).

(2) Crowns with noble or high noble metals. Payment will be approved pursuant to the criteria at 78.4(3)*"d"*(4).

e. Endodontic retreatment of a tooth. Payment will be approved pursuant to the criteria at 78.4(5)*"d."*

f. Occlusal guard. Payment will be approved pursuant to the criteria at 78.4(9)*"g."*

78.28(3) Optometric services and ophthalmic materials which must be submitted for prior approval are as follows:

a. A second lens correction within a 24-month period for members eight years of age and older. Payment shall be made when the member's vision has at least a five-tenths diopter of change in sphere or cylinder or ten-degree change in axis in either eye.

b. Visual therapy may be authorized when warranted by case history or diagnosis for a period of time not greater than 90 days. Should continued therapy be warranted, the prior approval process should be reaccomplished, accompanied by a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia. Visual therapy is not covered when provided by opticians.

c. Subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal aids include, but are not limited to, hand magnifiers, loupes, telescopic spectacles or reverse Galilean telescope systems.

d. Photochromatic tint. Approval shall be given when the member has a documented medical condition that causes photosensitivity and less costly alternatives are inadequate.

e. Press-on prisms. Approval shall be granted for members whose vision cannot be adequately corrected with other covered prisms.

For all of the above, the optometrist shall furnish sufficient information to clearly establish that these procedures are necessary in terms of the visual condition of the patient. (Cross references 78.6(4), 441—78.7(249A), and 78.1(18))

78.28(4) Hearing aids that must be submitted for prior approval are:

a. Replacement of a hearing aid less than four years old (except when the member is under 21 years of age). The department shall approve payment when the original hearing aid is lost or broken beyond repair or there is a significant change in the person's hearing that would require a different hearing aid. (Cross reference 78.14(7)*"d"*(1))

b. A hearing aid costing more than $650. The department shall approve payment for either of the following purposes (Cross reference 78.14(7)*"d"*(2)):

(1) Educational purposes when the member is participating in primary or secondary education or in a postsecondary academic program leading to a degree and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

(2) Vocational purposes when documentation submitted indicates the necessity, such as varying amounts of background noise in the work environment and a need to converse in order to do the job and an in-office comparison of an analog aid and a digital aid matched (+/- 5dB) for gain and output shows a significant improvement in either speech recognition in quiet or speech recognition in noise or an in-office comparison of two aids, one of which is single channel, shows significantly improved audibility.

78.28(5) Hospital services which must be subject to prior approval, preprocedure review or preadmission review are:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the hospital as long as the approval is obtained by the physician. (Cross reference 441—78.1(249A))

b. All inpatient hospital admissions are subject to retrospective review. Payment for inpatient hospital admissions which are retrospectively reviewed is approved when the claim meets the criteria for inpatient hospital care as determined by the IME medical services unit. Criteria are available from the IME medical services unit. (Cross reference 441—78.3(249A))

c. Preprocedure review by the IME medical services unit is required if hospitals are to be reimbursed for the inpatient and outpatient surgical procedures set forth in subrule 78.1(19). Approval by the IME medical services unit will be granted only if the procedures are determined to be medically necessary based on the condition of the patient and the criteria established by the department. The criteria are available from the IME medical services unit.

78.28(6) Ambulatory surgical centers are subject to prior approval and preprocedure review as follows:

a. Any medical or surgical procedure requiring prior approval as set forth in Chapter 78 is subject to the conditions for payment set forth although a request form does not need to be submitted by the ambulatory surgical center as long as the prior approval is obtained by the physician.

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

78.28(7) All assertive community treatment (ACT) services require prior approval. EXCEPTION: If ACT services are initiated before Medicaid eligibility is established, prior approval is required for ACT services beginning with the second month following notice of Medicaid eligibility.

a. Approval shall be granted if ACT services are determined to be medically necessary. Approval shall be limited to no more than 180 days.

b. A new prior approval must be obtained to continue ACT services after the expiration of a previous approval.

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

78.28(9) Private duty nursing or personal care services provided by a home health agency provider for persons aged 20 or under require prior approval and shall be approved if determined to be medically necessary. Payment shall be made on an hourly unit of service.

a. Definitions.

(1) Private duty nursing services are those services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals.

Services shall be provided according to a written plan of care authorized by a licensed physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment. These services shall exceed intermittent guidelines as defined in subrule 78.9(3). Private duty nursing and personal care services shall be inclusive of all home health agency services personally provided to the member.

Private duty nursing services do not include:

1. Respite care, which is a temporary intermission or period of rest for the caregiver.

2. Nurse supervision services including chart review, case discussion or scheduling by a registered nurse.

3. Services provided to other persons in the member's household.

4. Services requiring prior authorization that are provided without regard to the prior authorization process.

(2) Personal care services are those services provided by a home health aide or certified nurse's aide and which are delegated and supervised by a registered nurse under the direction of the member's physician to a member in the member's place of residence or outside the member's residence, when normal life activities take the member outside the place of residence. Place of residence does not include nursing facilities, intermediate care facilities for the mentally retarded, or hospitals. Payment for personal care services for persons aged 20 and under that exceed intermittent guidelines may be approved if determined to be medically necessary as defined in subrule 78.9(7). These services shall be in accordance with the member's plan of care and authorized by a physician. The home health agency is encouraged to collaborate with the member, or in the case of a child with the child's caregiver, in the development and implementation of the plan of treatment.

Medical necessity means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, threaten to cause or aggravate a disability or chronic illness, and no other equally effective course of treatment is available or suitable for the member requesting a service.

b. Requirements.

(1) Private duty nursing or personal care services shall be ordered in writing by a physician as evidenced by the physician's signature on the plan of care.

(2) Private duty nursing or personal care services shall be authorized by the department or the department's designated review agent prior to payment.

(3) Prior authorization shall be requested at the time of initial submission of the plan of care or at any time the plan of care is substantially amended and shall be renewed with the department or the department's designated review agent. Initial request for and request for renewal of prior authorization shall be submitted to the department's designated review agent. The provider of the service is responsible for requesting prior authorization and for obtaining renewal of prior authorization.

The request for prior authorization shall include a nursing assessment, the plan of care, and supporting documentation. The request for prior authorization shall include all items previously identified as required treatment plan information and shall further include: any planned surgical interventions and projected time frame; information regarding caregiver's desire to become involved in the member's care, to adhere to program objectives, to work toward treatment plan goals, and to work toward maximum independence; and identify the types and service delivery levels of all other services to the member whether or not the services are reimbursable by Medicaid. Providers shall indicate the expected number of private duty nursing RN hours, private duty nursing LPN hours, or home health aide hours per day, the number of days per week, and the number of weeks or months of service per discipline. If the member is currently hospitalized, the projected date of discharge shall be included.

Prior authorization approvals shall not be granted for treatment plans that exceed 16 hours of home health agency services per day. (Cross reference 78.9(10))

78.28(10) Replacement of vibrotactile aids less than four years old shall be approved when the original aid is broken beyond repair or lost. (Cross reference 78.10(3)*"b"*)

78.28(11) High-technology radiology procedures.

a. Except as provided in paragraph 78.28(11)*"b,"* the following radiology procedures require prior approval:

(1) Magnetic resonance imaging (MRIs);

(2) Computed tomography (CTs), including combined abdomen and pelvis CT scans;

(3) Computed tomographic angiographs (CTAs);

(4) Positron emission tomography (PETs); and

(5) Magnetic resonance angiography (MRAs).

b. Notwithstanding paragraph 78.28(11)*"a,"* prior authorization is not required when any of the following applies:

(1) Radiology procedures are billed on a CMS 1500 claim for places of service "hospital inpatient" (POS 21) or "hospital emergency room" (POS 23), or on a UB04 claim with revenue code 45X;

(2) The member has Medicare coverage;

(3) The member received notice of retroactive Medicaid eligibility after receiving a radiology procedure at a time prior to the member's receipt of such notice (see paragraph 78.28(11)*"e"*); or

(4) A radiology procedure is ordered or requested by the department of human services, a state district court, law enforcement, or other similar entity for the purposes of a child abuse/neglect investigation, as documented by the provider.

c. Prior approval will be granted if the procedure requested meets the requirements of 441—subrule 79.9(2), based on diagnosis, symptoms, history of illness, course of treatment, and treatment plan, as documented by the provider requesting prior approval.

d. Required requests for prior approval of radiology procedures must be submitted through the online system operated by the department's contractor for prior approval of high-technology radiology procedures.

e. Services are billed for members with retroactive eligibility.

(1) When a member has received notice of retroactive Medicaid eligibility after receiving a radiology procedure for a date of service prior to the member's receipt of such notice and otherwise requiring prior approval pursuant to this rule, a retroactive authorization request must be submitted on Form 470-0829, Request for Prior Authorization, before any claim for payment is submitted.

(2) Payment will be authorized only if the prior approval criteria were met and the service was provided to the member prior to the retroactive eligibility notification, as documented by the provider requesting retroactive authorization.

(3) Retroactive authorizations will not be granted when sought for reasons other than a member's retroactive Medicaid eligibility. Examples of such reasons include, but are not limited to, the following:

1. The provider was unaware of the high-technology radiology prior authorization requirement.
2. The provider was unaware that the member had current Medicaid eligibility or coverage.
3. The provider forgot to complete the required prior authorization process.

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

[**ARC 7548B**, IAB 2/11/09, effective 4/1/09; **ARC 8714B**, IAB 5/5/10, effective 5/1/10; **ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 9702B**, IAB 9/7/11, effective 9/1/11; **ARC 9883B**, IAB 11/30/11, effective 1/4/12; **ARC 0305C**, IAB 9/5/12, effective 11/1/12; **ARC 0631C**, IAB 3/6/13, effective 5/1/13; **ARC 0632C**, IAB 3/6/13, effective 5/1/13; **ARC 0823C**, IAB 7/10/13, effective 9/1/13; **ARC 1151C**, IAB 10/30/13, effective 1/1/14; **ARC 1696C**, IAB 10/29/14, effective 1/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.29(249A) Behavioral health services. Payment shall be made for medically necessary behavioral health services provided by a participating marital and family therapist, independent social worker, master social worker, mental health counselor, or certified alcohol and drug counselor within the practitioner's scope of practice pursuant to state law and subject to the limitations and exclusions set forth in this rule.

78.29(1) *Limitations.*

a. An assessment and a treatment plan are required.

b. Services provided by a licensed master social worker must be provided under the supervision of an independent social worker qualified to participate in the Medicaid program.

78.29(2) *Exclusions.* Payment will not be approved for the following services:

a. Services provided in a medical institution.

b. Services performed without relationship to a specific condition, risk factor, symptom, or complaint.

c. Services provided for nonspecific conditions of distress such as job dissatisfaction or general unhappiness.

d. Sensitivity training, marriage enrichment, assertiveness training, and growth groups or marathons.

78.29(3) *Payment.*

a. Payment shall be made only for time spent in face-to-face consultation with the member.

b. A unit of service is 15 minutes. Time spent with members shall be rounded to the quarter hour, where applicable.

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

[**ARC 9649B**, IAB 8/10/11, effective 8/1/11]

441—78.30(249A) Birth centers. Payment will be made for prenatal, delivery, and postnatal services.

78.30(1) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.30(2) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a birth center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.31(249A) Hospital outpatient services.

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

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

a. Emergency service.

b. Outpatient surgery.

c. Laboratory, X-ray and other diagnostic services.

d. General or family medicine.

e. Follow-up or after-care specialty clinics.

f. Physical medicine and rehabilitation.

g. Alcoholism and substance abuse.

h. Eating disorders.

i. Cardiac rehabilitation.

j. Mental health.

k. Pain management.

l. Diabetic education.

m. Pulmonary rehabilitation.

n. Nutritional counseling for persons aged 20 and under.

78.31(2) *Requirements for all outpatient services.*

a. *Need for service.* It must be clearly established that the service meets a documented need in the area served by the hospital. There must be documentation of studies completed, consultations with other health care facilities and health care professionals in the area, community leaders, and organizations to determine the need for the service and to tailor the service to meet that particular need.

b. *Professional direction.* All outpatient services must be provided by or at the direction and under the supervision of a medical doctor or osteopathic physician except for mental health services which may

be provided by or at the direction and under the supervision of a medical doctor, osteopathic physician, or certified health service provider in psychology.

c. *Goals and objectives.* The goals and objectives of the program must be clearly stated. Paragraphs *"d"* and *"f"* and the organization and administration of the program must clearly contribute to the fulfillment of the stated goals and objectives.

d. *Treatment modalities used.* The service must employ multiple treatment modalities and professional disciplines. The modalities and disciplines employed must be clearly related to the condition or disease being treated.

e. *Criteria for selection and continuing treatment of patients.* The condition or disease which is proposed to be treated must be clearly stated. Any indications for treatment or contraindications for treatment must be set forth together with criteria for determining the continued medical necessity of treatment.

f. *Length of program.* There must be established parameters that limit the program either in terms of its overall length or in terms of number of visits, etc.

g. *Monitoring of services.* The services provided by the program must be monitored and evaluated to determine the degree to which patients are receiving accurate assessments and effective treatment.

The monitoring of the services must be an ongoing plan and systematic process to identify problems in patient care or opportunities to improve patient care.

The monitoring and evaluation of the services are based on the use of clinical indicators that reflect those components of patient care important to quality.

h. *Vaccines.* In order to be paid for the outpatient administration of a vaccine covered under the Vaccines for Children (VFC) Program, a hospital must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.31(3) *Application for certification.* Hospital outpatient programs listed in subrule 78.31(1), paragraphs *"g"* to *"m,"* must submit an application to the Iowa Medicaid enterprise provider services unit for certification before payment will be made. The provider services unit will review the application against the requirements for the specific type of outpatient service and notify the provider whether certification has been approved.

Applications will consist of a narrative providing the following information:

a. Documented need for the program including studies, needs assessments, and consultations with other health care professionals.

b. Goals and objectives of the program.

c. Organization and staffing including how the program fits with the rest of the hospital, the number of staff, staff credentials, and the staff's relationship to the program, e.g., hospital employee, contractual consultant.

d. Policies and procedures including admission criteria, patient assessment, treatment plan, discharge plan and postdischarge services, and the scope of services provided, including treatment modalities.

e. Any accreditations or other types of approvals from national or state organizations.

f. The physical facility and any equipment to be utilized, and whether the facility is part of the hospital license.

78.31(4) *Requirements for specific types of service.*

a. Alcoholism and substance abuse.

(1) Approval by joint commission or substance abuse commission. In addition to certification by the department, alcoholism and substance abuse programs must also be approved by either the joint commission on the accreditation of hospitals or the Iowa substance abuse commission.

(2) General characteristics. The services must be designed to identify and respond to the biological, psychological and social antecedents, influences and consequences associated with the recipient's dependence.

These needed services must be provided either directly by the facility or through referral, consultation or contractual arrangements or agreements.

Special treatment needs of recipients by reason of age, gender, sexual orientation, or ethnic origin are evaluated and services for children and adolescents (as well as adults, if applicable) address the special needs of these age groups, including but not limited to, learning problems in education, family involvement, developmental status, nutrition, and recreational and leisure activities.

(3) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist and a substance abuse counselor certified by the Iowa board of substance abuse certification. Psychiatric consultation must be available and the number of staff should be appropriate to the patient load of the facility.

(4) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted which shall include:

A history of the use of alcohol and other drugs including age of onset, duration, patterns, and consequences of use; use of alcohol and drugs by family members and types of and responses to previous treatment.

A comprehensive medical history and physical examination including the history of physical problems associated with dependence.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

Any history of physical abuse.

A systematic mental status examination with special emphasis on immediate recall and recent and remote memory.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of alcoholism and other drug dependencies.

The patient's educational level, vocational status, and job performance history.

The patient's social support networks, including family and peer relationships.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and in programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission.

Legal problems, if applicable.

(5) Admission criteria. Both of the first two criteria and one additional criterion from the following list must be present for a patient to be accepted for treatment.

Alcohol or drugs taken in greater amounts over a longer period than the person intended.

Two or more unsuccessful efforts to cut down or control use of alcohol or drugs.

Continued alcohol or drug use despite knowledge of having a persistent or recurrent family, social, occupational, psychological, or physical problem that is caused or exacerbated by the use of alcohol or drugs.

Marked tolerance: the need for markedly increased amounts of alcohol or drugs (i.e., at least a 50 percent increase) in order to achieve intoxication or desired effect or markedly diminished effect with continued use of same amount.

Characteristic withdrawal symptoms.

Alcohol or drugs taken often to relieve or avoid withdrawal symptoms.

(6) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(7) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(8) Restrictions and limitations on payment. Medicaid will reimburse for a maximum of 28 treatment days. Payment beyond 28 days is made when documentation indicates that the patient has not reached an exit level.

If an individual has completed all or part of the basic 28-day program, a repeat of the program will be reimbursed with justification. The program will include an aftercare component meeting weekly for at least one year without charge.

b. Eating disorders.

(1) General characteristics. Eating disorders are characterized by gross disturbances in eating behavior. Eating disorders include anorexia nervosa or bulimia nervosa. Compulsive overeaters are not approved for this program.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented on the diagnostic and treatment staff, either through employment by a facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a licensed psychologist, a counselor with a master's or bachelor's degree and experience, a dietitian with a bachelor's degree and registered dietitian's certificate, and a licensed occupational therapist. The number of staff should be appropriate to the patient load of the facility.

(3) Initial assessment. A comprehensive assessment of the biological, psychological, social, and family orientation of the patient must be conducted. The assessment must include a weight history and a history of the patient's eating and dieting behavior, including binge eating, onset, patterns, and consequences. The assessment shall include the following:

A family history as well as self-assessment regarding chronic dieting, obesity, anorexia, bulimia, drug abuse, alcohol problems, depression, hospitalization for psychiatric reasons, and threatened or attempted suicide.

A history of purging behavior including frequency and history of vomiting, use of laxatives, history and frequency of use of diuretics, history and frequency of use of diet pills, ipecac, or any other weight control measures, and frequency of eating normal meals without vomiting.

A history of exercise behavior, including type, frequency, and duration.

A complete history of current alcohol and other drug use.

Any suicidal thoughts or attempts.

Sexual history, including sexual preference and activity. Sexual interest currently as compared to prior to the eating disorder is needed.

History of experiencing physical or sexual (incest or rape) abuse.

History of other counseling experiences.

Appropriate psychological assessment, including psychological orientation to the above questions.

A medical history, including a physical examination, covering the information listed in subparagraph (4) below.

Appropriate laboratory screening tests based on findings of the history and physical examination and tests for communicable diseases when indicated.

The patient's social support networks, including family and peer relationships.

The patient's educational level, vocational status, and job or school performance history, as appropriate.

The patient's leisure, recreational, or vocational interests and hobbies.

The patient's ability to participate with peers and programs and social activities.

Interview of family members and significant others as available with the patient's written or verbal permission as appropriate.

Legal problems, if applicable.

(4) Admission criteria. In order to be accepted for treatment, the patient shall meet the diagnostic criteria for anorexia nervosa or bulimia nervosa as established by the current version of the DSM (Diagnostic and Statistical Manual of Mental Disorders) published by the American Psychiatric Association.

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph *"a,"* subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac disrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a

licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

Patients are reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.32(249A) Area education agencies. Payment will be made for physical therapy, occupational therapy, psychological evaluations and counseling, psychotherapy, speech-language therapy, and audiological, nursing, and vision services provided by an area education agency (AEA). Services shall be provided directly by the AEA or through contractual arrangement with the AEA.

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

441—78.33(249A) Case management services. Payment will be approved for targeted case management services that are provided pursuant to 441—Chapter 90 to:

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

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

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

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9588B**, IAB 6/29/11, effective 9/1/11; **ARC 0848C**, IAB 7/24/13, effective 7/1/13; **ARC 1051C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to members eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.34(1) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.34(2) *Home health services.* Home health services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit.

a. Components of the service include, but are not limited to:

(1) Observation and reporting of physical or emotional needs.

(2) Helping a client with bath, shampoo, or oral hygiene.

(3) Helping a client with toileting.

(4) Helping a client in and out of bed and with ambulation.

(5) Helping a client reestablish activities of daily living.

(6) Assisting with oral medications ordered by the physician which are ordinarily self-administered.

(7) Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

(8) Accompaniment to medical services or transport to and from school.

b. In some cases, a nurse may provide home health services if the health of the client is such that the agency is unable to place an aide in that situation due to limitations by state law or in the event that the agency's Medicare certification requirements prohibit the aide from providing the service. It is not permitted for the convenience of the provider.

c. Skilled nursing care is not covered.

78.34(3) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.34(4) *Nursing care services.* Nursing care services are services which are included in the plan of treatment approved by the physician and which are provided by licensed nurses to consumers in the home and community. The services shall be reasonable and necessary to the treatment of an illness or injury and include all nursing tasks recognized by the Iowa board of nursing. A unit of service is a visit.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite, or group respite as defined in 441—Chapter 83.

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

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

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

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.34(7) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.34(7)*"f"* and the skilled activities listed in paragraph 78.34(7)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

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

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.34(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The required components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.34(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.34(13) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS health and disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.

3. Home-delivered meals.
4. Homemaker service.
5. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.34(13)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.34(13)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3).

(6) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph 78.34(13)*"b"*(2) or the utilization adjustment factor in subparagraph 78.34(13)*"b"*(3). Anticipated costs for home and vehicle modification shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.

6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.34(13)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.34(13)*"d."* The savings plan shall meet the requirements in paragraph 78.34(13)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. *Employment agreement.* Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. *Responsibilities of the independent support broker.* The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.34(14) *General service standards.* All ill and handicapped waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17]

441—78.35(249A) Occupational therapist services. Payment will be approved for the same services provided by an occupational therapist that are payable under Title XVIII of the Social Security Act (Medicare).

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

441—78.36(249A) Hospice services.

78.36(1) *General characteristics.* A hospice is a public agency or private organization or a subdivision of either that is primarily engaged in providing care to terminally ill individuals. A hospice provides palliative and supportive services to meet the physical, psychosocial, social and spiritual

needs of a terminally ill individual and the individual's family or other persons caring for the individual regardless of where the individual resides. Hospice services are those services to control pain and provide support to individuals to continue life with as little disruption as possible.

a. Covered services. Covered services shall include, in accordance with Medicare guidelines, the following:

(1) Nursing care.

(2) Medical social services.

(3) Physician services.

(4) Counseling services provided to the terminally ill individual and the individual's family members or other persons caring for the individual at the individual's place of residence, including bereavement, dietary, and spiritual counseling.

(5) Short-term inpatient care provided in a participating hospice inpatient unit or a participating hospital or nursing facility that additionally meets the special hospice standards regarding staffing and patient areas for pain control, symptom management and respite purposes.

(6) Medical appliances and supplies, including drugs and biologicals, as needed for the palliation and management of the individual's terminal illness and related conditions, except for "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

(7) Homemaker and home health aide services.

(8) Physical therapy, occupational therapy and speech-language pathology unless this provision has been waived under the Medicare program for a specific provider.

(9) Other items or services specified in the resident's plan that would otherwise be paid under the Medicaid program.

Nursing care, medical social services, and counseling are core hospice services and must routinely be provided directly by hospice employees. The hospice may contract with other providers to provide the remaining services. Bereavement counseling, consisting of counseling services provided after the individual's death to the individual's family or other persons caring for the individual, is a required hospice service but is not reimbursable.

b. Noncovered services.

(1) Covered services not related to the terminal illness. In accordance with Medicare guidelines, all medical services related to the terminal illness are the responsibility of the hospice. Services unrelated to the terminal illness are to be billed separately by the respective provider.

(2) Administrative duties performed by the medical director, any hospice-employed physician, or any consulting physician are included in the normal hospice rates. Patient care provided by the medical director, hospice-employed physician, attending physician, or consulting physician is separately reimbursable. Payment to the attending or consulting physician includes other partners in practice.

(3) Hospice care provided by a hospice other than the hospice designated by the individual unless provided under arrangements made by the designated hospice.

(4) AZT (Retrovir) and other curative antiviral drugs targeted at the human immunodeficiency virus for the treatment of AIDS.

78.36(2) *Categories of care.* Hospice care entails the following four categories of daily care. Guidelines for core and other services must be adhered to for all categories of care.

a. Routine home care is care provided in the place of residence that is not continuous.

b. Continuous home care is provided only during a period of crisis when an individual requires continuous care which is primarily nursing care to achieve palliation or management of acute medical symptoms. Nursing care must be provided by either a registered nurse or a licensed practical nurse and a nurse must be providing care for more than half of the period of care. A minimum of eight hours of care per day must be provided during a 24-hour day to qualify as continuous care. Homemaker and aide services may also be provided to supplement the nursing care.

c. Inpatient respite care is provided to the individual only when necessary to relieve the family members or other persons caring for the individual at home. Respite care may be provided only on an

occasional basis and may not be reimbursed for more than five consecutive days at a time. Respite care may not be provided when the individual is a resident of a nursing facility.

d. General inpatient care is provided in periods of acute medical crisis when the individual is hospitalized or in a participating hospice inpatient unit or nursing facility for pain control or acute or chronic symptom management.

78.36(3) *Residence in a nursing facility.* For purposes of the Medicaid hospice benefit, a nursing facility can be considered the residence of a beneficiary. When the person does reside in a nursing facility, the requirement that the care of a resident of a nursing facility must be provided under the immediate direction of either the facility or the resident's personal physician does not apply if all of the following conditions are met:

a. The resident is terminally ill.

b. The resident has elected to receive hospice services under the Medicaid program from a Medicaid-enrolled hospice program.

c. The nursing facility and the Medicaid-enrolled hospice program have entered into a written agreement under which the hospice program takes full responsibility for the professional management of the resident's hospice care and the facility agrees to provide room and board to the resident.

78.36(4) *Approval for hospice benefits.* Payment will be approved for hospice services to individuals who are certified as terminally ill, that is, the individuals have a medical prognosis that their life expectancy is six months or less if the illness runs its normal course, and who elect hospice care rather than active treatment for the illness.

a. Physician certification process. The hospice must obtain certification that an individual is terminally ill in accordance with the following procedures:

(1) The hospice may obtain verbal orders to initiate hospice service from the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The verbal order shall be noted in the patient's record. The verbal order must be given within two days of the start of care and be followed up in writing no later than eight calendar days after hospice care is initiated. The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less if the illness runs its normal course.

(2) When verbal orders are not secured, the hospice must obtain, no later than two calendar days after hospice care is initiated, written certification signed by the medical director of the hospice or the physician member of the hospice interdisciplinary group and by the individual's attending physician (if the individual has an attending physician). The certification must include the statement that the individual's medical prognosis is that the individual's life expectancy is six months or less, if the illness runs its normal course.

(3) Hospice care benefit periods consist of up to two periods of 90 days each and an unlimited number of subsequent 60-day periods as elected by the individual. The medical director or a physician must recertify at the beginning of each benefit period that the individual is terminally ill.

b. Election procedures. Individuals who are dually eligible for Medicare and Medicaid must receive hospice coverage under Medicare.

(1) Election statement. An individual, or individual's representative, elects to receive the hospice benefit by filing an election statement, Form 470-2618, Election of Medicaid Hospice Benefit, with a particular hospice. The hospice may provide the individual with another election form to use provided the form includes the following information:

1. Identification of the hospice that will provide the care.
2. Acknowledgment that the recipient has been given a full understanding of hospice care.
3. Acknowledgment that the recipient waives the right to regular Medicaid benefits, except for payment to the regular physician and treatment for medical conditions unrelated to the terminal illness.
4. Acknowledgment that recipients are not responsible for copayment or other deductibles.
5. The recipient's Medicaid number.
6. The effective date of election.
7. The recipient's signature.

(2) Change of designation. An individual may change the designation of the particular hospice from which the individual elects to receive hospice care one time only.

(3) Effective date. An individual may designate an effective date for the hospice benefit that begins with the first day of the hospice care or any subsequent day of hospice care, but an individual may not designate an effective date that is earlier than the date that the election is made.

(4) Duration of election. The election to receive hospice care will be considered to continue until one of the following occurs:

1. The individual dies.
2. The individual or the individual's representative revokes the election.
3. The individual's situation changes so that the individual no longer qualifies for the hospice benefit.
4. The hospice elects to terminate the recipient's enrollment in accordance with the hospice's established discharge policy.

(5) Revocation. Form 470-2619, Revocation of Medicaid Hospice Benefit, is completed when an individual or the individual's representative revokes the hospice benefit allowed under Medicaid. When an individual revokes the election of Medicaid coverage of hospice care, the individual resumes Medicaid coverage of the benefits waived when hospice care was elected.

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

441—78.37(249A) HCBS elderly waiver services. Payment will be approved for the following services to members eligible for the HCBS elderly waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.37(1) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.37(2) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.37(3) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service include:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.37(4) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.37(5) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services are reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous, hypodermoclysis, and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services and informing the physician and other personnel of changes in the patient's condition and needs.

A unit of service is one visit. Nursing care service can pay for a maximum of eight nursing visits per month for intermediate level of care persons. There is no limit on the maximum visits for skilled level of care persons.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

78.37(7) *Chore services.* Chore services provide assistance with the household maintenance activities listed in paragraph 78.37(7)*"a,"* as necessary to allow a member to remain in the member's own home safely and independently. A unit of service is 15 minutes.

a. Chore services are limited to the following services:

(1) Window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows;

(2) Minor repairs to walls, floors, stairs, railings and handles;

(3) Heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care, painting, and trash removal;

(4) Lawn mowing and removal of snow and ice from sidewalks and driveways.

b. Leaf raking, bush and tree trimming, trash burning, stick removal, and tree removal are not covered services.

78.37(8) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.
(17) Telecommunications device for the deaf.
(18) Exterior hard-surface pathways.
(19) New door opening.
(20) Pocket doors.
(21) Installation or relocation of controls, outlets, switches.
(22) Air conditioning and air filtering if medically necessary.
(23) Heightening of existing garage door opening to accommodate modified van.
(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.37(10) *Mental health outreach.* Mental health outreach services are services provided in a recipient's home to identify, evaluate, and provide treatment and psychosocial support. The services can only be provided on the basis of a referral from the consumer's interdisciplinary team established pursuant to 441—subrule 83.22(2). A unit of service is 15 minutes.

78.37(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.37(12) *Nutritional counseling.* Nutritional counseling services may be provided for a nutritional problem or condition of such a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. A unit of service is 15 minutes.

78.37(13) *Assistive devices.* Assistive devices means practical equipment products to assist persons with activities of daily living and instrumental activities of daily living to allow the person more independence. They include, but are not limited to: long-reach brush, extra long shoehorn, nonslip grippers to pick up and reach items, dressing aids, shampoo rinse tray and inflatable shampoo tray, double-handled cup and sipper lid. A unit is an item.

a. The service shall be included in the member's service plan and shall exceed the services available under the Medicaid state plan.

b. The service shall be provided following prior approval by the Iowa Medicaid enterprise.

c. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.37(14) *Senior companion.* Senior companion services are nonmedical care supervision, oversight, and respite. Companions may assist with such tasks as meal preparation, laundry, shopping and light housekeeping tasks. This service cannot provide hands-on nursing or medical care. A unit of service is 15 minutes.

78.37(15) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.37(15)*"f"* and the skilled activities listed in paragraph 78.37(15)*"g."* Covered service activities must be essential to the health, safety, and welfare

of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual, agency or assisted living facility that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Assisted living agreements with Iowa Medicaid members must specify the services to be considered covered under the assisted living occupancy agreement and those CDAC services to be covered under the elderly waiver. The funding stream for each service must be identified.

(3) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care individual and agency providers must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Assisted living facilities may choose to use Form 470-4389 or may devise another system that adheres to the requirements of rule 441—79.3(249A). Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual, agency or assisted living facility. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.37(16) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS elderly waiver are:

1. Assistive devices.
2. Chore service.
3. Consumer-directed attendant care (unskilled).
4. Home and vehicle modification.
5. Home-delivered meals.
6. Homemaker service.
7. Basic individual respite care.
8. Senior companion.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.37(16)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.37(16)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and assistive devices are not subject to the average cost in subparagraph 78.37(16)*"b"*(2) or the utilization adjustment factor in subparagraph 78.37(16)*"b"*(3). Anticipated costs for home and vehicle modification and assistive devices shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. Costs

for home and vehicle modification and assistive devices may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. *Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. *Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.37(16)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.

12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or assistive device. When authorized, the budget may include an amount allocated for a home or vehicle modification or an assistive device. Before becoming part of the individual budget, all home and vehicle modifications and assistive devices shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or device.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.37(16)*"d."* The savings plan shall meet the requirements in paragraph 78.37(16)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.37(17) *Case management services.* Case management services are services that assist Medicaid members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member. Case management is provided at the direction of the member and the interdisciplinary team established pursuant to 441—subrule 83.22(2).

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Case management shall not include the provision of direct services by the case managers.

c. Payment for case management shall not be made until the consumer is enrolled in the waiver. Payment shall be made only for case management services performed on behalf of the consumer during a month when the consumer is enrolled.

78.37(18) *Assisted living service.* The assisted living service includes unanticipated and unscheduled personal care and supportive services that are furnished to waiver participants who reside in a homelike, noninstitutional setting. The service includes the 24-hour on-site response capability to meet unpredictable member needs as well as member safety and security through incidental supervision. Assisted living service is not reimbursable if performed at the same time as any service included in an approved consumer-directed attendant care (CDAC) agreement.

a. A unit of service is one day.

b. A day of assisted living service is billable only if both the following requirements are met:

(1) The member was present in the facility during that day's bed census.

(2) The assisted living provider has documented at least one assisted living service encounter for that day, in accordance with rule 441—79.3(249A). The documentation must include the member's response to the service. The documented assisted living service cannot also be an authorized CDAC service.

78.37(19) *General service standards.* All elderly waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0545C**, IAB 1/9/13, effective 3/1/13; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2340C**, IAB 1/6/16, effective 2/10/16]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to members eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.38(1) *Counseling services.* Counseling services are face-to-face mental health services provided to the member and caregiver by a mental health professional as defined in rule 441—24.1(225C) to facilitate home management of the member and prevent institutionalization. Counseling services are

nonpsychiatric services necessary for the management of depression, assistance with the grief process, alleviation of psychosocial isolation and support in coping with a disability or illness, including terminal illness. Counseling services may be provided both for the purpose of training the member's family or other caregiver to provide care, and for the purpose of helping the member and those caring for the member to adjust to the member's disability or terminal condition. Counseling services may be provided to the member's caregiver only when included in the case plan for the member.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver member or the waiver member and the member's caregiver is 15 minutes. A unit of group counseling is 15 minutes. Payment for group counseling is based on the group rate divided by six, or, if the number of persons who comprise the group exceeds six, the actual number of persons who comprise the group.

78.38(2) *Home health aide services.* Home health aide services are personal or direct care services provided to the client which are not payable under Medicaid as set forth in rule 441—78.9(249A). A unit of service is a visit. Components of the service are:

a. Observation and reporting of physical or emotional needs.

b. Helping a client with bath, shampoo, or oral hygiene.

c. Helping a client with toileting.

d. Helping a client in and out of bed and with ambulation.

e. Helping a client reestablish activities of daily living.

f. Assisting with oral medications ordinarily self-administered and ordered by a physician.

g. Performing incidental household services which are essential to the client's health care at home and are necessary to prevent or postpone institutionalization in order to complete a full unit of service.

78.38(3) *Homemaker services.* Homemaker services are those services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions. A unit of service is 15 minutes. Components of the service must be directly related to the care of the member and may include only the following:

a. Essential shopping: shopping for basic need items such as food, clothing or personal care items, or drugs.

b. Limited housecleaning: maintenance cleaning such as vacuuming, dusting, scrubbing floors, defrosting refrigerators, cleaning stoves, cleaning medical equipment, washing and mending clothes, washing personal items used by the member, and washing dishes.

c. Meal preparation: planning and preparing balanced meals.

78.38(4) *Nursing care services.* Nursing care services are services provided by licensed agency nurses to clients in the home which are ordered by and included in the plan of treatment established by the physician. The services shall be reasonable and necessary to the treatment of an illness or injury and include: observation; evaluation; teaching; training; supervision; therapeutic exercise; bowel and bladder care; administration of medications; intravenous and enteral feedings; skin care; preparation of clinical and progress notes; coordination of services; and informing the physician and other personnel of changes in the patient's conditions and needs. A unit of service is a visit.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

78.38(6) *Home-delivered meals.* Home-delivered meals are meals prepared elsewhere and delivered to a member at the member's residence.

a. Each meal shall ensure the member receives a minimum of one-third of the daily recommended dietary allowance as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement which meets the minimum one-third standard.

b. When a restaurant provides the home-delivered meal, the member is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the member and what constitutes the minimum one-third daily dietary allowance.

c. A maximum of two meals is allowed per day. A unit of service is a meal.

78.38(7) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.38(8)*"f"* and the skilled activities listed in paragraph 78.38(8)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensive, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.38(9) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS AIDS/HIV waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home-delivered meals.
3. Homemaker service.
4. Basic individual respite care.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.38(9)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.38(9)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.38(9)*"b"*(3).

(6) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.38(9)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.

3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.

4. Costs associated with shipping items to the member.

5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.

7. Home furnishings.

8. Home repairs or home maintenance.

9. Homeopathic treatments.

10. Insurance premiums or copayments.

11. Items purchased on installment payments.

12. Motorized vehicles.

13. Nutritional supplements.

14. Personal entertainment items.

15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.38(9)*"d."* The savings plan shall meet the requirements in paragraph 78.38(9)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed

personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.38(10) *General service standards.* All AIDS/HIV waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14]

441—78.39(249A) Federally qualified health centers. Payment shall be made for services as defined in Section 1905(a)(2)(C) of the Social Security Act.

78.39(1) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, federally qualified health centers, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.39(2) *Risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

78.39(3) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a federally qualified health center must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.40(249A) Advanced registered nurse practitioners. Payment shall be approved for services provided by advanced registered nurse practitioners within their scope of practice and the limitations of state law, with the exception of services not payable to physicians under rule 441—78.1(249A) or otherwise not payable under any other applicable rule.

78.40(1) *Direct payment.* Payment shall be made to advanced registered nurse practitioners directly, without regard to whether the advanced registered nurse practitioner is employed by or associated with a physician, hospital, birth center, clinic or other health care provider recognized under state law. An established protocol between a physician and the advanced registered nurse practitioner shall not cause an advanced registered nurse practitioner to be considered auxiliary personnel of a physician, or an employee of a hospital, birth center, or clinic.

78.40(2) *Location of service.* Payment shall be approved for services rendered in any location in which the advanced registered nurse practitioner is legally authorized to provide services under state law. The nurse practitioner shall have promptly available the necessary equipment and personnel to handle emergencies.

78.40(3) *Utilization review.* Utilization review shall be conducted of Medicaid members who access more than 24 outpatient visits in any 12-month period from physicians, advanced registered nurse practitioners, other clinics, and emergency rooms. Refer to rule 441—76.9(249A) for further information concerning the member lock-in program.

78.40(4) *Vaccines.* In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, an advanced registered nurse practitioner must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

78.40(5) *Prenatal risk assessment.* Risk assessment, using Form 470-2942, Medicaid Prenatal Risk Assessment, shall be completed at the initial visit during a Medicaid member's pregnancy.

a. If the risk assessment reflects a low-risk pregnancy, the assessment shall be completed again at approximately the twenty-eighth week of pregnancy.

b. If the risk assessment reflects a high-risk pregnancy, referral shall be made for enhanced services. (See description of enhanced services at subrule 78.25(3).)

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.41(249A) HCBS intellectual disability waiver services. Payment will be approved for the following services to members eligible for the HCBS intellectual disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

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

a. Available components of the service are personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions that interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

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

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service will provide supervision or structure in identified periods when another resource is not available.

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

c. Services may be provided to a child or an adult. A maximum of four persons may reside in a living unit.

(1) A member may live within the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Maintenance and room and board costs are not reimbursable.

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

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.41(1)*"f"*(1) does not apply.

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

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

(2) 20,440 15-minute units are available per state fiscal year except a leap year when 20,496 15-minute units are available.

h. The service shall be identified in the member's service plan.

i. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

i. Payment for respite services shall not exceed $7,334.62 per the member's waiver year.

78.41(3) *Personal emergency response or portable locator system.*

a. The personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of the system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.41(4) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the

cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.41(5) *Nursing services.* Nursing services are individualized in-home medical services provided by licensed nurses. Services shall exceed the Medicaid state plan services and be included in the consumer's individual comprehensive plan.

a. A unit of service is one hour.

b. A maximum of ten units are available per week.

78.41(6) *Home health aide services.* Home health aide services are personal or direct care services provided to the member which are not payable under Medicaid as set forth in rule 441—78.9(249A). Services shall include unskilled medical services and shall exceed those services provided under HCBS intellectual disability waiver supported community living. Instruction, supervision, support or assistance in personal hygiene, bathing, and daily living shall be provided under supported community living.

a. Services shall be included in the member's service plan.

b. A unit is one hour.

c. A maximum of 14 units are available per week.

78.41(7) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.41(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.41(8)*"f"* and the skilled activities listed in paragraph 78.41(8)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. Nonskilled services. Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. Skilled services. Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.41(9) *Interim medical monitoring and treatment services.* Interim medical monitoring and treatment (IMMT) services are monitoring and treatment of a medical nature for children or adults whose medical needs make alternative care unavailable, inadequate, or insufficient. IMMT services are not intended to provide day care but to supplement available resources. Services must be ordered by a physician.

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.41(10) *Residential-based supported community living services.* Residential-based supported community living services are medical or remedial services provided to children under the age of 18 while living outside their home in a residential-based living environment furnished by the residential-based supported community living service provider. The services eliminate barriers to family reunification or develop self-help skills for maximum independence.

a. Allowable service components are the following:

(1) Daily living skills development. These are services to develop the child's ability to function independently in the community on a daily basis, including training in food preparation, maintenance of living environment, time and money management, personal hygiene, and self-care.

(2) Social skills development. These are services to develop a child's communication and socialization skills, including interventions to develop a child's ability to solve problems, resolve conflicts, develop appropriate relationships with others, and develop techniques for controlling behavior.

(3) Family support development. These are services necessary to allow a child to return to the child's family or another less restrictive service environment. These services must include counseling and therapy sessions that involve both the child and the child's family at least 50 percent of the time and that focus on techniques for dealing with the special care needs of the child and interventions needed to alleviate behaviors that are disruptive to the family or other group living unit.

(4) Counseling and behavior intervention services. These are services to halt, control, or reverse stress and social, emotional, or behavioral problems that threaten or have negatively affected the child's stability. Activities under this service include counseling and behavior intervention with the child, including interventions to ameliorate problem behaviors.

b. Residential-based supported community living services must also address the ordinary daily-living needs of the child, excluding room and board, such as needs for safety and security, social functioning, and other medical care.

c. Residential-based supported community living services do not include services associated with vocational needs, academics, day care, Medicaid case management, other case management, or any other services that the child can otherwise obtain through Medicaid.

d. Room and board costs are not reimbursable as residential-based supported community living services.

e. The scope of service shall be identified in the child's service plan pursuant to 441—paragraph 77.37(23)*"d."*

f. Residential-based supported community living services shall not be simultaneously reimbursed with other residential services provided under an HCBS waiver or otherwise provided under the Medicaid program.

g. A unit of service is a day.

h. The maximum number of units of residential-based supported community living services available per child is 365 daily units per state fiscal year, except in a leap year when 366 daily units are available.

78.41(11) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.41(12) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.41(13) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.41(14) *Day habilitation services.*

a. *Scope.* Day habilitation services are services that assist or support the member in developing or maintaining life skills and community integration. Services must enable or enhance the member's intellectual functioning, physical and emotional health and development, language and communication development, cognitive functioning, socialization and community integration, functional skill development, behavior management, responsibility and self-direction, daily living activities, self-advocacy skills, or mobility.

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

c. *Unit of service.* Except as provided in paragraph 78.41(14)*"b,"* the unit of service is 15 minutes (for up to 16 units per day) or a full day (4.25 to 8 hours per day).

d. *Exclusions.*

(1) Services shall not be provided in the member's home, except as provided in paragraph *"b."* For this purpose, services provided in a residential care facility where the member lives are not considered to be provided in the member's home.

(2) Services shall not include vocational or prevocational services and shall not involve paid work.

(3) Services shall not duplicate or replace education or related services defined in Public Law 94-142, the Education of the Handicapped Act.

(4) Services shall not be provided simultaneously with other Medicaid-funded services.

78.41(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. Individual budget amount. A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS intellectual disabilities waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Supported community living.
7. Supported employment.
8. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.41(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.41(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.41(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.41(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Costs for home and vehicle modification and supported employment services to obtain a job may be paid to the financial management services provider in a one-time payment. Before becoming part of the individual budget, all home and vehicle modifications and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and

community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.41(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification. When authorized, the budget may include an amount allocated for a home or vehicle modification. Before becoming part of the individual budget, all home and vehicle modifications shall be identified in the member's service plan and approved

by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.41(15)*"d."* The savings plan shall meet the requirements in paragraph 78.41(15)*"f."*

f. Savings plan. A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and
3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. Responsibilities of the financial management service. The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.
2. Collecting and processing timecards.
3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.
4. Computing and processing other withholdings, as applicable.
5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.
6. Preparing and issuing employee payroll checks.
7. Preparing and disbursing IRS Forms W-2 and W-3 annually.
8. Processing federal advance earned income tax credit for eligible employees.
9. Refunding over-collected FICA, when appropriate.
10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.41(16) *General service standards.* All intellectual disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17]

441—78.42(249A) Pharmacies administering influenza vaccine to children. Payment will be made to a pharmacy for the administration of influenza vaccine available through the Vaccines for Children (VFC) Program administered by the department of public health if the pharmacy is enrolled in the VFC program. Payment will be made for the vaccine only if the VFC program stock has been depleted.

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

[**ARC 9132B**, IAB 10/6/10, effective 11/1/10; **ARC 9316B**, IAB 12/29/10, effective 2/2/11; **ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.43(249A) HCBS brain injury waiver services. Payment shall be approved for the following services to members eligible for the HCBS brain injury waiver services as established in 441—Chapter 83 and as identified in the member's service plan.

78.43(1) *Case management services.* Individual case management services means services that assist members who reside in a community setting or are transitioning to a community setting in gaining access to needed medical, social, educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.

a. Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. The service shall be delivered in such a way as to enhance the capabilities of consumers and their families to exercise their rights and responsibilities as citizens in the community. The goal is to enhance the ability of the consumer to exercise choice, make decisions, take risks that are a typical part of life, and fully participate as members of the community.

c. The case manager must develop a relationship with the consumer so that the abilities, needs and desires of the consumer can be clearly identified and communicated and the case manager can help to ensure that the system and specific services are responsive to the needs of the individual consumers.

d. Members who are eligible for targeted case management are not eligible for case management as a waiver service.

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

a. The basic components of the service may include, but are not limited to, personal and home skills training services, individual advocacy services, community skills training services, personal environment support services, transportation, and treatment services.

(1) Personal and home skills training services are activities which assist a member to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) Individual advocacy is the act or process of representing the member's rights and interests in order to realize the rights to which the member is entitled and to remove barriers to meeting the member's needs.

(3) Community skills training services are activities which assist a member to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they apply to the member being served:

1. Personal management skills training services are activities which assist a member to maintain or develop skills necessary to sustain the member in the physical environment and are essential to the management of the member's personal business and property. This includes self-advocacy skills. Examples of personal management skills are the ability to maintain a household budget, plan and

prepare nutritional meals, use community resources such as public transportation and libraries, and select foods at the grocery store.

2. Socialization skills training services are activities which assist a member to develop or maintain skills which include self-awareness and self-control, social responsiveness, community participation, social amenities, and interpersonal skills.

3. Communication skills training services are activities which assist a member to develop or maintain skills including expressive and receptive skills in verbal and nonverbal language and the functional application of acquired reading and writing skills.

(4) Personal and environmental support services are those activities and expenditures provided to or on behalf of a member in the areas of personal needs in order to allow the member to function in the least restrictive environment.

(5) Transportation services are activities and expenditures designed to assist the member to travel from one place to another to obtain services or carry out life's activities. The services exclude transportation provided as nonemergency medical transportation pursuant to rule 441—78.13(249A).

(6) Treatment services are activities designed to assist the member to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to the member's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment includes medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. Physiological treatment shall be provided by or under the direct supervision of a certified or licensed health care professional.

2. Psychotherapeutic treatment means activities provided to assist a member in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the member's functioning in response to the physical, emotional, and social environment.

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

(1) Supported community living services shall be available at a daily rate to members living outside the home of their family, legal representative, or foster family and for whom a provider has primary responsibility for supervision or structure during the month. This service shall provide supervision or structure in identified periods when another resource is not available.

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

c. Services may be provided to a child or an adult. Children must first access all other services for which they are eligible and which are appropriate to meet their needs before accessing the HCBS brain injury waiver services. A maximum of four persons may reside in a living unit.

(1) A member may live in the home of the member's family or legal representative or in another typical community living arrangement.

(2) A member living with the member's family or legal representative is not subject to the maximum of four residents in a living unit.

(3) A member may not live in a licensed medical or health care facility or in a setting that is required to be licensed as a medical or health care facility.

d. A member aged 17 or under living in the home of the member's family, legal representative, or foster family shall receive services based on development of adaptive, behavior, or health skills. Duration of services shall be based on age-appropriateness and individual attention span.

e. Provider budgets shall reflect all staff-to-member ratios and shall reflect costs associated with members' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each member. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs

shall not exceed $1570 per member per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a member residing in the living unit receives on-site staff supervision for eight or more hours per day as an average over a calendar month and the member's service plan identifies and reflects the need for this amount of supervision.

(2) Fifteen minutes when subparagraph 78.43(2)*"e"*(1) does not apply.

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

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

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

g. The service shall be identified in the member's service plan.

h. Supported community living services shall not be simultaneously reimbursed with other residential services or with respite, transportation, personal assistance, nursing, or home health aide services provided through Medicaid or the HCBS brain injury waiver.

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

a. Services provided outside the member's home shall not be reimbursable if the living unit where respite is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite care cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

78.43(4) *Supported employment services.* Supported employment services are service activities provided pursuant to subrule 78.27(10).

78.43(5) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.

2. A remote, portable activator.

3. A central monitoring station with backup systems staffed by trained attendants at all times.

4. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law

enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.

2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.43(7) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service when the transportation costs are included within the supported community living reimbursement rate.

78.43(8) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a brain injury and which:

(1) Provide for health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service. Each month within the 12-month period, the service worker shall encumber an amount within the monthly dollar cap allowed for the member until the amount of the equipment cost is reached.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.43(9) *Adult day care services.* Adult day care services provide an organized program of supportive care in a group environment to persons who need a degree of supervision and assistance on a regular or intermittent basis in a day care center. A unit of service is 15 minutes (up to four units per day), a half day (1.25 to 4 hours per day), a full day (4.25 to 8 hours per day), or an extended day (8.25 to 12 hours per day). Components of the service include health-related care, social services, and other related support services.

78.43(10) *Family counseling and training services.* Family counseling and training services are face-to-face mental health services provided to the consumer and the family with whom the consumer lives, or who routinely provide care to the consumer to increase the consumer's or family members' capabilities to maintain and care for the consumer in the community. Counseling may include helping the consumer or the consumer's family members with crisis, coping strategies, stress reduction, management of depression, alleviation of psychosocial isolation and support in coping with the effects

of a brain injury. It may include the use of treatment regimes as specified in the ITP. Periodic training updates may be necessary to safely maintain the consumer in the community.

Family may include spouse, children, friends, or in-laws of the consumer. Family does not include individuals who are employed to care for the consumer.

78.43(11) *Prevocational services.* Prevocational services are service activities provided pursuant to subrule 78.27(9).

78.43(12) *Behavioral programming.* Behavioral programming consists of individually designed strategies to increase the consumer's appropriate behaviors and decrease the consumer's maladaptive behaviors which have interfered with the consumer's ability to remain in the community. Behavioral programming includes:

a. A complete assessment of both appropriate and maladaptive behaviors.

b. Development of a structured behavioral intervention plan which should be identified in the ITP.

c. Implementation of the behavioral intervention plan.

d. Ongoing training and supervision to caregivers and behavioral aides.

e. Periodic reassessment of the plan.

Types of appropriate behavioral programming include, but are not limited to, clinical redirection, token economies, reinforcement, extinction, modeling, and over-learning.

78.43(13) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.43(13)*"f"* and the skilled activities listed in paragraph 78.43(13)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. *Service planning.*

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. *Supervision of skilled services.* Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. *Service documentation.* The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. *Role of guardian or attorney.* If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. *Service units and billing.* A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. Excluded services and costs. Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

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

a. Need for service. The member must be currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. The service worker or case manager must identify the need for IMMT services after evaluating the member's living environment, family and natural supports, ability to perform activities of daily living, and health care needs. The services must be needed:

(1) To allow the member's usual caregivers to be employed,

(2) During a search for employment by a usual caregiver,

(3) To allow for academic or vocational training of a usual caregiver,

(4) Due to the hospitalization of a usual caregiver for treatment for physical or mental illness, or

(5) Due to the death of a usual caregiver.

b. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each member's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a member with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis. Medical intervention means the ability to assess the situation and contact the appropriate medical professional, not the direct application of medical care.

c. Interim medical monitoring and treatment services may include supervision while the member is being transported to and from school.

d. Limitations.

(1) A maximum of 12 hours of service is available per day.

(2) Covered services do not include a complete nutritional regimen.

(3) Interim medical monitoring and treatment services may not duplicate any regular Medicaid or waiver services provided under the state plan. Services under the state plan, including home health agency services under rule 441—78.9(249A), must be exhausted before IMMT services are accessed.

(4) Interim medical monitoring and treatment services shall be provided only in the member's home; in a registered child development home; in a licensed child care center, residential care facility, or adult day care facility; or during the time when the member is being transported to and from school.

(5) The member-to-staff ratio shall not be more than six members to one staff person.

(6) The parent or guardian of the member shall be responsible for the usual and customary nonmedical cost of day care during the time in which the member is receiving IMMT services. Medical care necessary for monitoring and treatment is an allowable IMMT cost. If the cost of care goes above the usual and customary cost of day care services due to the member's medical condition, the costs above the usual and customary cost shall be covered as IMMT services.

e. A unit of service is 15 minutes.

78.43(15) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and based on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS brain injury waiver are:

1. Consumer-directed attendant care (unskilled).
2. Day habilitation.
3. Home and vehicle modification.
4. Prevocational services.
5. Basic individual respite care.
6. Specialized medical equipment.
7. Supported community living.
8. Supported employment.
9. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.43(15)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.43(15)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3).

(6) Anticipated costs for home and vehicle modification, specialized medical equipment, and supported employment services to obtain a job are not subject to the average cost in subparagraph 78.43(15)*"b"*(2) or the utilization adjustment factor in subparagraph 78.43(15)*"b"*(3). Anticipated costs for these services shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications, specialized medical equipment, and supported employment services to obtain a job shall be identified in the member's service plan and approved by the case manager or service worker. Costs for these services may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. Required service components. To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. Optional service components. A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. Development of the individual budget. The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.43(15)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.

6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.
16. Room and board, including rent or mortgage payments.
17. School tuition.
18. Service animals.
19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.
20. Sheltered workshop services.
21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.
22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.43(15)*"d."* The savings plan shall meet the requirements in paragraph 78.43(15)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.
2. The amount of the individual budget allocated each month to the savings plan.
3. The amount of the individual budget allocated each month to meet the member's identified service needs.
4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,
2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. Budget authority. The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.43(16) *General service standards.* All brain injury waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17]

441—78.44(249A) Lead inspection services. Payment shall be approved for lead inspection services. This service shall be provided for children who have had two venous blood lead levels of 15 to 19 micrograms per deciliter or one venous level greater than or equal to 20 micrograms per deciliter. This service includes, but is not limited to, X-ray fluorescence analyzer (XRF) readings, visual examination of paint, preventive education of the resident and homeowner, health education about lead poisoning, and a written report to the family, homeowner, medical provider, and local childhood lead poisoning prevention program.

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

441—78.45(249A) Assertive community treatment. Assertive community treatment (ACT) services are comprehensive, integrated, and intensive outpatient services provided by a multidisciplinary team under the supervision of a psychiatrist. ACT services are directed toward the rehabilitation of behavioral, social, or emotional deficits or the amelioration of symptoms of a mental disorder. Most services are delivered in the member's home or another community setting.

78.45(1) *Applicability.* ACT services may be provided only to a member who meets all of the following criteria:

a. The member is at least 17 years old.

b. The member has a severe and persistent mental illness or complex mental health symptomatology. A severe and persistent mental illness is a psychiatric disorder that causes symptoms and impairments in basic mental and behavioral processes that produce distress and major functional disability in adult role functioning (such as social, personal, family, educational or vocational roles). Specifically, the member has a degree of impairment arising from a psychiatric disorder such that:

(1) The member does not have the resources or skills necessary to maintain an adequate level of functioning in the home or community environment without assistance or support;

(2) The member's judgment, impulse control, or cognitive perceptual abilities are compromised; and

(3) The member exhibits significant impairment in social, interpersonal, or familial functioning.

c. The member has a validated principal mental health diagnosis consistent with a severe and persistent mental illness. For this purpose, a mental health diagnosis means a disorder, dysfunction, or dysphoria diagnosed pursuant to the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding neurodevelopmental disorders, substance-related disorders, personality disorders, medication-induced movement disorders and other adverse effects of medication, and other conditions that may be a focus of clinical attention. Members with a primary diagnosis of substance-related disorder, developmental disability, or organic disorder are not eligible for ACT services.

d. The member needs a consistent team of professionals and multiple mental health and support services to maintain the member in the community and reduce hospitalizations, as evidenced by:

(1) A pattern of repeated treatment failures with at least two hospitalizations within the previous 24 months, or

(2) A need for multiple or combined mental health and basic living supports to prevent the need for a more intrusive level of care.

e. The member presents a reasonable likelihood that ACT services will lead to specific, observable improvements in the member's functioning and assist the member in achieving or maintaining community tenure. Specifically, the member:

(1) Is medically stable;

(2) Does not require a level of care that includes more intensive medical monitoring;

(3) Presents a low risk to self, others, or property, with treatment and support; and

(4) Lives independently in the community or demonstrates a capacity to live independently and move from a dependent residential setting to independent living.

f. At the time of admission, the member has a comprehensive assessment that includes psychiatric history, medical history, work and educational history, substance use, problems with activities of daily living, social interests, and family relationships.

g. The member has a written treatment plan containing a work evaluation and the necessary psychiatric rehabilitation treatment and support services. The plan shall identify:

(1) Treatment objectives and outcomes,

(2) The expected frequency and duration of each service,

(3) The location where the services will be provided,

(4) A crisis plan, and

(5) The schedule for updates of the treatment plan.

78.45(2) *Services.* The ACT team shall participate in all mental health services provided to the member and shall provide 24-hour service for the psychiatric needs of the member. Available ACT services are:

a. Evaluation and medication management.

(1) The evaluation portion of ACT services consists of a comprehensive mental health evaluation and assessment of the member by a psychiatrist, advanced registered nurse practitioner, or physician assistant.

(2) Medication management consists of the prescription and management of medication by a psychiatrist, advanced registered nurse practitioner, or physician assistant to respond to the member's complaints and symptoms. A psychiatric registered nurse assists in this management by contact with the member regarding medications and their effect on the member's complaints and symptoms.

b. Integrated therapy and counseling for mental health and substance abuse. This service consists of direct counseling for treatment of mental health and substance abuse symptoms by a psychiatrist, licensed mental health professional, advanced registered nurse practitioner, physician assistant, or substance abuse specialist. Individual counseling is provided by other team members under the supervision of a psychiatrist or licensed mental health practitioner.

c. *Skill teaching.* Skill teaching consists of side-by-side demonstration and observation of daily living activities by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant.

d. *Community support.* Community support is provided by a licensed mental health professional, psychologist, substance abuse counselor, peer specialist, community support specialist, advanced registered nurse practitioner, or physician assistant. Community support consists of the following activities focused on recovery and rehabilitation:

(1) Personal and home skills training to assist the member to develop and maintain skills for self-direction and coping with the living situation.

(2) Community skills training to assist the member in maintaining a positive level of participation in the community through development of socialization skills and personal coping skills.

e. *Medication monitoring.* Medication monitoring services are provided by a psychiatric nurse and other team members under the supervision of a psychiatrist or psychiatric nurse and consist of:

(1) Monitoring the member's day-to-day functioning, medication compliance, and access to medications; and

(2) Ensuring that the member keeps appointments.

f. *Case management for treatment and service plan coordination.* Case management consists of the development by the ACT team of an individualized treatment and service plan, including personalized goals and outcomes, to address the member's medical symptoms and remedial functional impairments.

(1) Case management includes:

1. Assessments, referrals, follow-up, and monitoring.

2. Assisting the member in gaining access to necessary medical, social, educational, and other services.

3. Assessing the member to determine service needs by collecting relevant historical information through member records and other information from relevant professionals and natural supports.

(2) The team shall:

1. Develop a specific care plan based on the assessment of needs, including goals and actions to address the needed medical, social, educational, and other necessary services.

2. Make referrals to services and related activities to assist the member with the assessed needs.

3. Monitor and perform follow-up activities necessary to ensure that the plan is carried out and that the member has access to necessary services. Activities may include monitoring contacts with providers, family members, natural supports, and others.

4. Hold daily team meetings to facilitate ACT services and coordinate the member's care with other members of the team.

g. *Crisis response.* Crisis response consists of direct assessment and treatment of the member's urgent or crisis symptoms in the community by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant, as appropriate.

h. *Work-related services.* Work-related services may be provided by a registered nurse, licensed mental health professional, psychologist, substance abuse counselor, community support specialist, case manager, advanced registered nurse practitioner, or physician assistant. Services consist of assisting the member in managing mental health symptoms as they relate to job performance. Services may include:

(1) Collaborating with the member to look for job situations that may cause symptoms to increase and creating strategies to manage these situations.

(2) Assisting the member to develop or enhance skills to obtain a work placement, such as individual work-related behavioral management.

(3) Providing supports to maintain employment, such as crisis intervention related to employment.

(4) Teaching communication, problem solving, and safety skills.

(5) Teaching personal skills such as time management and appropriate grooming for employment.

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

[**ARC 9440B**, IAB 4/6/11, effective 4/1/11; **ARC 1850C**, IAB 2/4/15, effective 4/1/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to members eligible for the HCBS physical disability waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.46(1) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a member with self-care tasks which the member would typically do independently if the member were otherwise able. Covered service activities are limited to the nonskilled activities listed in paragraph 78.46(1)*"f"* and the skilled activities listed in paragraph 78.46(1)*"g."* Covered service activities must be essential to the health, safety, and welfare of the member. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advance direction for the service provision.

a. Service planning.

(1) The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall:

1. Select the individual or agency that will provide the components of the attendant care services.

2. Determine with the selected provider what components of attendant care services the provider shall perform, subject to confirmation by the service worker or case manager that those components are consistent with the assessment and are authorized covered services.

3. Complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, to indicate the frequency, scope, and duration of services (a description of each service component and the time agreed on for that component). The case manager or service worker and provider shall also sign the agreement.

4. Submit the completed agreement to the service worker or case manager. The agreement shall be part of the member's service plan and shall be kept in the member's records, in the provider's records, and in the service worker's or case manager's records. Any service component that is not listed in the agreement shall not be payable.

(2) Whenever a legal representative acts as a provider of consumer-directed attendant care as allowed by 441—paragraph 79.9(7)*"b,"* the following shall apply:

1. The payment rate for the legal representative must be based on the skill level of the legal representative and may not exceed the median statewide reimbursement rate for the service unless the higher rate receives prior approval from the department;

2. The legal representative may not be paid for more than 40 hours of service per week; and

3. A contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

b. Supervision of skilled services. Skilled consumer-directed attendant care services shall be provided under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall:

(1) Retain accountability for actions that are delegated.

(2) Ensure appropriate assessment, planning, implementation, and evaluation.

(3) Make on-site supervisory visits every two weeks with the service provider present.

c. Service documentation. The consumer-directed attendant care provider must complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service. Any service component that is not documented in accordance with rule 441—79.3(249A) shall not be payable.

d. Role of guardian or attorney. If the member has a guardian or attorney in fact under a durable power of attorney for health care:

(1) The service worker's or case manager's service plan shall address how consumer-directed attendant care services will be monitored to ensure that the member's needs are being adequately met. If the guardian or attorney in fact is the service provider, the service plan shall address how the service worker or case manager shall oversee service provision.

(2) The guardian or attorney in fact shall sign the claim form in place of the member, indicating that the service has been provided as presented on the claim.

e. Service units and billing. A unit of service is 15 minutes provided by an individual or agency. Each service shall be billed in whole units.

f. *Nonskilled services.* Covered nonskilled service activities are limited to help with the following activities:

(1) Dressing.

(2) Bathing, shampooing, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general.

(4) Toileting, including bowel, bladder, and catheter assistance (emptying the catheter bag, collecting a specimen, and cleaning the external area around the catheter).

(5) Meal preparation, cooking, and assistance with feeding, not including the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping, laundry, and shopping essential to the member's health care at home.

(7) Taking medications ordinarily self-administered, including those ordered by a physician or other qualified health care provider.

(8) Minor wound care.

(9) Going to or returning from a place of employment and job-related tasks while the member is on the job site. Transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Tasks, such as financial management and scheduling, that require cognitive or physical assistance.

(11) Communication essential to the health and welfare of the member, through interpreting and reading services and use of assistive devices for communication.

(12) Using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

g. *Skilled services.* Covered skilled service activities are limited to help with the following activities:

(1) Tube feedings of members unable to eat solid foods.

(2) Intravenous therapy administered by a registered nurse.

(3) Parenteral injections required more than once a week.

(4) Catheterizations, continuing care of indwelling catheters with supervision of irrigations, and changing of Foley catheters when required.

(5) Respiratory care including inhalation therapy and tracheotomy care or tracheotomy care and ventilator.

(6) Care of decubiti and other ulcerated areas, noting and reporting to the nurse or therapist.

(7) Rehabilitation services including, but not limited to, bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, behavior modification, and reteaching of the activities of daily living.

(8) Colostomy care.

(9) Care of uncontrolled medical conditions, such as brittle diabetes, and comfort care of terminal conditions.

(10) Postsurgical nursing care.

(11) Monitoring medications requiring close supervision because of fluctuating physical or psychological conditions, e.g., antihypertensives, digitalis preparations, mood-altering or psychotropic drugs, or narcotics.

(12) Preparing and monitoring response to therapeutic diets.

(13) Recording and reporting of changes in vital signs to the nurse or therapist.

h. *Excluded services and costs.* Services, activities, costs and time that are not covered as consumer-directed attendant care include the following (not an exclusive list):

(1) Any activity related to supervising a member. Only direct services are billable.

(2) Any activity that the member is able to perform.

(3) Costs of food.

(4) Costs for the supervision of skilled services by the nurse or therapist. The supervising nurse or therapist may be paid from private insurance, Medicare, or other third-party payment sources, or may

be paid as another Medicaid service, including early and periodic screening, diagnosis and treatment services.

(5) Exercise that does not require skilled services.

(6) Parenting or child care for or on behalf of the member.

(7) Reminders and cueing.

(8) Services provided simultaneously with any other similar service regardless of funding source, including other waiver services and state supplementary assistance in-home health-related care services.

(9) Transportation costs.

(10) Wait times for any activity.

78.46(2) *Home and vehicle modification.* Covered home or vehicle modifications are physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the member's medical or remedial need and that would be expected to increase the fair market value of the home or vehicle, such as furnaces, fencing, or adding square footage to the residence, are excluded except as specifically included below. Purchasing or leasing of a motorized vehicle is excluded. Home and vehicle repairs are also excluded.

b. Only the following modifications are covered:

(1) Kitchen counters, sink space, cabinets, special adaptations to refrigerators, stoves, and ovens.

(2) Bathtubs and toilets to accommodate transfer, special handles and hoses for shower heads, water faucet controls, and accessible showers and sink areas.

(3) Grab bars and handrails.

(4) Turnaround space adaptations.

(5) Ramps, lifts, and door, hall and window widening.

(6) Fire safety alarm equipment specific for disability.

(7) Voice-activated, sound-activated, light-activated, motion-activated, and electronic devices directly related to the member's disability.

(8) Vehicle lifts, driver-specific adaptations, remote-start systems, including such modifications already installed in a vehicle.

(9) Keyless entry systems.

(10) Automatic opening device for home or vehicle door.

(11) Special door and window locks.

(12) Specialized doorknobs and handles.

(13) Plexiglas replacement for glass windows.

(14) Modification of existing stairs to widen, lower, raise or enclose open stairs.

(15) Motion detectors.

(16) Low-pile carpeting or slip-resistant flooring.

(17) Telecommunications device for the deaf.

(18) Exterior hard-surface pathways.

(19) New door opening.

(20) Pocket doors.

(21) Installation or relocation of controls, outlets, switches.

(22) Air conditioning and air filtering if medically necessary.

(23) Heightening of existing garage door opening to accommodate modified van.

(24) Bath chairs.

c. A unit of service is the completion of needed modifications or adaptations.

d. All modifications and adaptations shall be provided in accordance with applicable federal, state, and local building and vehicle codes.

e. Services shall be performed following prior department approval of the modification as specified in 441—subrule 79.1(17) and a binding contract between the provider and the member.

f. All contracts for home or vehicle modification shall be awarded through competitive bidding. The contract shall include the scope of work to be performed, the time involved, supplies needed, the cost, diagrams of the project whenever applicable, and an assurance that the provider has liability and workers' compensation coverage and the applicable permit and license.

g. Service payment shall be made to the enrolled home or vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home or vehicle modification provider following completion of the approved modifications. Payment of up to $6,366.64 per year may be made to certified providers upon satisfactory completion of the service.

h. Services shall be included in the member's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response or portable locator system.*

a. A personal emergency response system is an electronic device that transmits a signal to a central monitoring station to summon assistance in the event of an emergency.

(1) The necessary components of a system are:

1. An in-home medical communications transceiver.
2. A remote, portable activator.
3. A central monitoring station with backup systems staffed by trained attendants at all times.
4. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each member.

(2) The service shall be identified in the member's service plan.

(3) A unit of service is a one-time installation fee or one month of service.

(4) Maximum units per state fiscal year shall be the initial installation and 12 months of service.

b. A portable locator system is an electronic device that transmits a signal to a monitoring device. The system allows a member to access assistance in the event of an emergency and allows law enforcement or the monitoring system provider to locate a member who is unable to request help or to activate a system independently. The member must be unable to access assistance in an emergency situation due to the member's age or disability.

(1) The required components of the portable locator system are:

1. A portable communications transceiver or transmitter to be worn or carried by the member.
2. Monitoring by the provider at a central location with response protocols and personal, medical, and emergency information for each member as applicable.

(2) The service shall be identified in the member's service plan.

(3) Payable units of service are purchase of equipment, an installation or set-up fee, and monthly fees.

(4) Maximum units per state fiscal year shall be one equipment purchase, one installation or set-up fee, and 12 months of service.

78.46(4) *Specialized medical equipment.*

a. Specialized medical equipment shall include medically necessary items which are for personal use by members with a physical disability and which:

(1) Provide for the health and safety of the member,

(2) Are not ordinarily covered by Medicaid,

(3) Are not funded by educational or vocational rehabilitation programs, and

(4) Are not provided by voluntary means.

b. Coverage includes, but is not limited to:

(1) Electronic aids and organizers.

(2) Medicine dispensing devices.

(3) Communication devices.

(4) Bath aids.

(5) Noncovered environmental control units.

(6) Repair and maintenance of items purchased through the waiver.

c. Payment of up to $6,366.64 per year may be made to enrolled specialized medical equipment providers upon satisfactory receipt of the service.

d. The need for specialized medical equipment shall be:

(1) Documented by a health care professional as necessary for the member's health and safety, and

(2) Identified in the member's service plan.

e. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

78.46(5) *Transportation.* Transportation services may be provided for members to conduct business errands and essential shopping, to travel to and from work or day programs, and to reduce social isolation. A unit of service is one mile of transportation or one one-way trip.

78.46(6) *Consumer choices option.* The consumer choices option provides a member with a flexible monthly individual budget that is based on the member's service needs. With the individual budget, the member shall have the authority to purchase goods and services to meet the member's assessed needs and may choose to employ providers of services and supports. The services, supports, and items that are purchased with an individual budget must be directly related to a member's assessed need or goal established in the member's service plan. Components of this service are set forth below.

a. *Agreement.* As a condition of participating in the consumer choices option, a member shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the member has been informed of the responsibilities and risks of electing the consumer choices option.

b. *Individual budget amount.* A monthly individual budget amount shall be established for each member based on the assessed needs of the member and on the services and supports authorized in the member's service plan. The member shall be informed of the individual budget amount during the development of the service plan.

(1) Services that may be included in determining the individual budget amount for a member in the HCBS physical disability waiver are:

1. Consumer-directed attendant care (unskilled).
2. Home and vehicle modification.
3. Specialized medical equipment.
4. Transportation.

(2) The department shall determine an average unit cost for each service listed in subparagraph 78.46(6)*"b"*(1) based on actual unit costs from the previous fiscal year plus a cost-of-living adjustment.

(3) In aggregate, costs for individual budget services shall not exceed the current costs of waiver program services. In order to maintain cost neutrality, the department shall apply a utilization adjustment factor to the amount of service authorized in the member's service plan before calculating the value of that service to be included in the individual budget amount.

(4) The department shall compute the utilization adjustment factor for each service by dividing the net costs of all claims paid for the service by the total of the authorized costs for that service, using at least 12 consecutive months of aggregate service data. The utilization adjustment factor shall be no lower than 60 percent. The department shall analyze and adjust the utilization adjustment factor at least annually in order to maintain cost neutrality.

(5) Individual budgets for respite services shall be computed based on the average cost for services identified in subparagraph 78.46(6)*"b"*(2). Respite services are not subject to the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3).

(6) Anticipated costs for home and vehicle modification and specialized medical equipment are not subject to the average cost in subparagraph 78.46(6)*"b"*(2) or the utilization adjustment factor in subparagraph 78.46(6)*"b"*(3). Anticipated costs for home and vehicle modification and specialized medical equipment shall not include the costs of the financial management services or the independent support broker. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. Costs for home and vehicle modification and specialized medical equipment may be paid to the financial management services provider in a one-time payment.

(7) The individual budget amount may be changed only at the first of the month and shall remain fixed for the entire month.

c. *Required service components.* To participate in the consumer choices option, a member must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid provider. Before hiring the independent support broker, the member shall receive the results of the background check conducted pursuant to 441—Chapter 119.

d. *Optional service components.* A member who elects the consumer choices option may purchase the following goods, services and supports, which shall be provided in the member's home or at an integrated community setting:

(1) Self-directed personal care services. Self-directed personal care services are services or goods that provide a range of assistance in activities of daily living and incidental activities of daily living that help the member remain in the home and community. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the member in developing and maintaining independence and community integration. These services must be identified in the member's service plan developed by the member's case manager or service worker.

(3) Individual-directed goods and services. Individual-directed goods and services are services, equipment, or supplies not otherwise provided through the Medicaid program that address an assessed need or goal identified in the member's service plan. The item or service shall meet the following requirements:

1. Promote opportunities for community living and inclusion.
2. Increase independence or substitute for human assistance, to the extent the expenditures would otherwise be made for that human assistance.
3. Be accommodated within the member's budget without compromising the member's health and safety.
4. Be provided to the member or directed exclusively toward the benefit of the member.
5. Be the least costly to meet the member's needs.
6. Not be available through another source.

e. *Development of the individual budget.* The independent support broker shall assist the member in developing and implementing the member's individual budget. The individual budget shall include:

(1) The costs of the financial management service.

(2) The costs of the independent support broker. The independent support broker may be compensated for up to 6 hours of service for assisting with the implementation of the initial individual budget. The independent support broker shall not be paid for more than 30 hours of service for an individual member during a 12-month period without prior approval by the department.

(3) The costs of any optional service component chosen by the member as described in paragraph 78.46(6)*"d."* Costs of the following items and services shall not be covered by the individual budget:

1. Child care services.
2. Clothing not related to an assessed medical need.
3. Conference, meeting or similar venue expenses other than the costs of approved services the member needs while attending the conference, meeting or similar venue.
4. Costs associated with shipping items to the member.
5. Experimental and non-FDA-approved medications, therapies, or treatments.
6. Goods or services covered by other Medicaid programs.
7. Home furnishings.
8. Home repairs or home maintenance.
9. Homeopathic treatments.
10. Insurance premiums or copayments.
11. Items purchased on installment payments.
12. Motorized vehicles.
13. Nutritional supplements.
14. Personal entertainment items.
15. Repairs and maintenance of motor vehicles.

16. Room and board, including rent or mortgage payments.

17. School tuition.

18. Service animals.

19. Services covered by third parties or services that are the responsibility of a non-Medicaid program.

20. Sheltered workshop services.

21. Social or recreational purchases not related to an assessed need or goal identified in the member's service plan.

22. Vacation expenses, other than the costs of approved services the member needs while on vacation.

(4) The costs of any approved home or vehicle modification or specialized medical equipment. When authorized, the budget may include an amount allocated for a home or vehicle modification or specialized medical equipment. Before becoming part of the individual budget, all home and vehicle modifications and specialized medical equipment shall be identified in the member's service plan and approved by the case manager or service worker. The authorized amount shall not be used for anything other than the specific modification or equipment.

(5) Any amount set aside in a savings plan to reserve funds for the future purchase of self-directed personal care, individual-directed goods and services, or self-directed community supports and services as defined in paragraph 78.46(6)*"d."* The savings plan shall meet the requirements in paragraph 78.46(6)*"f."*

f. *Savings plan.* A member savings plan must be in writing and be approved by the department before the start of the savings plan. Amounts allocated to the savings plan must result from efficiencies in meeting identified needs of the member.

(1) The savings plan shall identify:

1. The specific goods, services, supports or supplies to be purchased through the savings plan.

2. The amount of the individual budget allocated each month to the savings plan.

3. The amount of the individual budget allocated each month to meet the member's identified service needs.

4. How the member's assessed needs will continue to be met through the individual budget when funds are placed in savings.

(2) With the exception of funds allocated for respite care, the savings plan shall not include funds budgeted for direct services that were not received. The budgeted amount associated with unused direct services other than respite care shall revert to the Medicaid program at the end of each month. Funds from unused respite services may be allocated to the savings plan but shall not be used for anything other than future respite care.

(3) Funds accumulated under a savings plan shall be used only to purchase items that increase independence or substitute for human assistance to the extent that expenditures would otherwise be made for human assistance, including additional goods, supports, services or supplies. The self-directed personal care, individual-directed goods and services, or self-directed community supports and services purchased with funds from a savings plan must:

1. Be used to meet a member's identified need,

2. Be medically necessary, and

3. Be approved by the member's case manager or service worker.

(4) All funds allocated to a savings plan that are not expended by December 31 of each year shall revert to the Medicaid program.

(5) The annual reassessment of a member's needs must take into account the purchases of goods and services that substitute for human assistance. Adjustments shall be made to the services used to determine the individual budget based on the reassessment.

g. *Budget authority.* The member shall have authority over the individual budget authorized by the department to perform the following tasks:

(1) Contract with entities to provide services and supports as described in this subrule.

(2) Determine the amount to be paid for services. Reimbursement rates shall be consistent with rates paid by others in the community for the same or substantially similar services. Reimbursement rates for the independent support broker and the financial management service are subject to the limits in 441—subrule 79.1(2). The reimbursement rate for a member's legal representative who provides services to the member as allowed by 441—paragraph 79.9(7)*"b"* 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.

(3) Schedule the provision of services. Whenever a member's legal representative provides services to the member as allowed by 441—paragraph 79.9(7)*"b,"* the legal representative may not be paid for more than 40 hours of service per week and a contingency plan must be established in the member's service plan to ensure service delivery in the event the legal representative is unable to provide services due to illness or other unexpected event.

(4) Authorize payment for waiver goods and services optional service components identified in the individual budget.

(5) Reallocate funds among services included in the budget. Every purchase of a good or service must be identified and approved in the individual budget before the purchase is made.

h. Delegation of budget authority. The member may delegate responsibility for the individual budget to a representative in addition to the independent support broker.

(1) The representative must be at least 18 years old.

(2) The representative shall not be a current provider of service to the member.

(3) The member shall sign a consent form that designates who the member has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

i. Employer authority. The member shall have the authority to be the common-law employer of employees providing services and support under the consumer choices option. A common-law employer has the right to direct and control the performance of the services. The member may perform the following functions:

(1) Recruit employees.

(2) Select employees from a worker registry.

(3) Verify employee qualifications.

(4) Specify additional employee qualifications.

(5) Determine employee duties.

(6) Determine employee wages and benefits.

(7) Schedule employees.

(8) Train and supervise employees.

j. Employment agreement. Any person employed by the member to provide services under the consumer choices option shall sign an employment agreement with the member that outlines the employee's and member's responsibilities.

k. Responsibilities of the independent support broker. The independent support broker shall perform the following services as directed by the member or the member's representative:

(1) Assist the member with developing the member's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the member for the first four months of implementation of the initial individual budget and have quarterly contact thereafter.

(3) Complete the required employment packet with the financial management service.

(4) Assist with interviewing potential employees and entities providing services and supports if requested by the member.

(5) Assist the member with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the member with obtaining a signed consent from a potential employee to conduct background checks if requested by the member.

(7) Assist the member with negotiating with entities providing services and supports if requested by the member.

(8) Assist the member with contracts and payment methods for services and supports if requested by the member.

(9) Assist the member with developing an emergency backup plan. The emergency backup plan shall address any health and safety concerns.

(10) Review expenditure reports from the financial management service to ensure that services and supports in the individual budget are being provided.

(11) Document in writing on the independent support broker timecard every contact the broker has with the member. Contact documentation shall include information on the extent to which the member's individual budget has addressed the member's needs and the satisfaction of the member.

l. *Responsibilities of the financial management service.* The financial management service shall perform all of the following services:

(1) Receive Medicaid funds in an electronic transfer.

(2) Process and pay invoices for approved goods and services included in the individual budget.

(3) Enter the individual budget into the Web-based tracking system chosen by the department and enter expenditures as they are paid.

(4) Provide real-time individual budget account balances for the member, the independent support broker, and the department, available at a minimum during normal business hours (9 a.m. to 5 p.m., Monday through Friday).

(5) Conduct criminal background checks on potential employees pursuant to 441—Chapter 119.

(6) Verify for the member an employee's citizenship or alien status.

(7) Assist the member with fiscal and payroll-related responsibilities including, but not limited to:

1. Verifying that hourly wages comply with federal and state labor rules.

2. Collecting and processing timecards.

3. Withholding, filing, and paying federal, state and local income taxes, Medicare and Social Security (FICA) taxes, and federal (FUTA) and state (SUTA) unemployment and disability insurance taxes, as applicable.

4. Computing and processing other withholdings, as applicable.

5. Processing all judgments, garnishments, tax levies, or other withholding on an employee's pay as may be required by federal, state, or local laws.

6. Preparing and issuing employee payroll checks.

7. Preparing and disbursing IRS Forms W-2 and W-3 annually.

8. Processing federal advance earned income tax credit for eligible employees.

9. Refunding over-collected FICA, when appropriate.

10. Refunding over-collected FUTA, when appropriate.

(8) Assist the member in completing required federal, state, and local tax and insurance forms.

(9) Establish and manage documents and files for the member and the member's employees.

(10) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each member for a total of five years.

(11) Provide to the department, the independent support broker, and the member monthly and quarterly status reports that include a summary of expenditures paid and amount of budget unused.

(12) Establish an accessible customer service system and a method of communication for the member and the independent support broker that includes alternative communication formats.

(13) Establish a customer services complaint reporting system.

(14) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(15) Develop a business continuity plan in the case of emergencies and natural disasters.

(16) Provide to the department an annual independent audit of the financial management service.

(17) Assist in implementing the state's quality management strategy related to the financial management service.

78.46(7) *General service standards.* All physical disability waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

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

[**ARC 9045B**, IAB 9/8/10, effective 11/1/10; **ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1071C**, IAB 10/2/13, effective 10/1/13; **ARC 1610C**, IAB 9/3/14, effective 8/13/14; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17]

441—78.47(249A) Pharmaceutical case management services. Payment will be approved for pharmaceutical case management services provided by an eligible physician and pharmacist for Medicaid recipients determined to be at high risk for medication-related problems. These services are designed to identify, prevent, and resolve medication-related problems and improve drug therapy outcomes.

78.47(1) *Medicaid recipient eligibility.* Patients are eligible for pharmaceutical case management services if they have active prescriptions for four or more regularly scheduled nontopical medications, are ambulatory, do not reside in a nursing facility, and have at least one of the eligible disease states of congestive heart disease, ischemic heart disease, diabetes mellitus, hypertension, hyperlipidemia, asthma, depression, atrial fibrillation, osteoarthritis, gastroesophageal reflux, or chronic obstructive pulmonary disease.

78.47(2) *Provider eligibility.* Physicians and pharmacists shall meet the following criteria to provide pharmaceutical case management services.

a. Physicians and pharmacists must be enrolled in the Iowa Medicaid program, have an Iowa Medicaid provider number, and receive training under the direction of the department regarding the provision of pharmaceutical case management services under the Iowa Medicaid program.

A copy of pharmaceutical case management records, including documentation of services provided, shall be maintained on file in each provider's facility and be made available for audit by the department on request.

b. Physicians shall be licensed to practice medicine.

c. Pharmacists shall present to the department evidence of competency including state licensure, submit five acceptable patient care plans, and have successfully completed professional training on patient-oriented, medication-related problem prevention and resolution. Pharmacists shall also maintain problem-oriented patient records, provide a private patient consultation area, and submit a statement indicating that the submitted patient care plans are representative of the pharmacists' usual patient care plans.

Acceptable professional training programs are:

(1) A doctor of pharmacy degree program.

(2) The Iowa Center for Pharmaceutical Care (ICPC) training program, which is a cooperative training initiative of the University of Iowa College of Pharmacy, Drake University College of Pharmacy and Health Sciences, and the Iowa Pharmacy Foundation.

(3) Other programs containing similar coursework and supplemental practice site evaluation and reengineering, approved by the department with input from a peer review advisory committee.

78.47(3) *Services.* Eligible patients may choose whether to receive the services. If patients elect to receive the services, they must receive the services from any eligible physician and pharmacist acting as a pharmaceutical case management (PCM) team. Usually the eligible physician and pharmacist will be the patient's primary physician and pharmacist. Pharmaceutical case management services are to be value-added services complementary to the basic medical services provided by the primary physician and pharmacist.

The PCM team shall provide the following services:

a. *Initial assessment.* The initial assessment shall consist of:

(1) A patient evaluation by the pharmacist, including:

1. Medication history;
2. Assessment of indications, effectiveness, safety, and compliance of medication therapy;
3. Assessment for the presence of untreated illness; and
4. Identification of medication-related problems such as unnecessary medication therapy, suboptimal medication selection, inappropriate compliance, adverse drug reactions, and need for additional medication therapy.

(2) A written report and recommendation from the pharmacist to the physician.

(3) A patient care action plan developed by the PCM team with the patient's agreement and implemented by the PCM team. Specific components of the action plan will vary based on patient needs and conditions but may include changes in medication regimen, focused patient or caregiver education, periodic assessment for changes in the patient's condition, periodic monitoring of the effectiveness of medication therapy, self-management training, provision of patient-specific educational and informational materials, compliance enhancement, and reinforcement of healthy lifestyles. An action plan must be completed for each initial assessment.

b. *New problem assessments.* These assessments are initiated when a new medication-related problem is identified. The action plan is modified and new components are implemented to address the new problem. This assessment may occur in the interim between scheduled follow-up assessments.

c. *Problem follow-up assessments.* These assessments are based on patient need and a problem identified by a prior assessment. The patient's status is evaluated at an appropriate interval. The effectiveness of the implemented action plan is determined and modifications are made as needed.

d. *Preventive follow-up assessments.* These assessments occur approximately every six months when no current medication-related problems have been identified in prior assessments. The patient is reassessed for newly developed medication-related problems and the action plan is reviewed.

This rule is intended to implement Iowa Code section 249A.4 and 2000 Iowa Acts, chapter 1228, section 9.

441—78.48(249A) Public health agencies. Payments will be made to local public health agencies on a fee schedule basis for providing vaccine and vaccine administration and testing for communicable disease. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a public health agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

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

[**ARC 0358C**, IAB 10/3/12, effective 11/7/12]

441—78.49(249A) Infant and toddler program services. Subject to the following subrules, payment shall be made for medical services provided to Medicaid eligible children by infant and toddler program providers under the infants and toddlers with disabilities program administered by the Iowa Child Health Specialty Clinics and the departments of education, public health, and human services.

78.49(1) *Covered services.* Covered services include, but are not limited to, audiology, psychological evaluation and counseling, health and nursing services, nutrition services, occupational

therapy services, physical therapy services, developmental services, speech-language services, vision services, case management, and medical transportation.

78.49(2) *Case management services.* Payment shall also be approved for infant and toddler case management services subject to the following requirements:

a. Definition. "Case management" means services that will assist eligible children in gaining access to needed medical, social, educational, and other services. Case management is intended to address the complexities of coordinated service delivery for children with medical needs. The case manager should be the focus for coordinating and overseeing the effectiveness of all providers and programs in responding to the assessed need. Case management does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible child has been referred or any activities that are an integral part or an extension of the direct services.

b. Choice of provider. Children who also are eligible to receive targeted case management services under 441—Chapter 90 must choose whether to receive case management through the infant and toddler program or through 441—Chapter 90. The chosen provider must meet the requirements of this subrule.

(1) When a child resides in a medical institution, the institution is responsible for case management. The child is not eligible for any other case management services. However, noninstitutional case management services may be provided during the last 14 days before the child's planned discharge if the child's stay in the institution has been less than 180 consecutive days. If the child has been in the institution 180 consecutive days or longer, the child may receive noninstitutional case management services during the last 60 days before the child's planned discharge.

(2) If the case management agency also provides direct services, the case management unit must be designed so that conflict of interest is addressed and does not result in self-referrals.

(3) If the costs of any part of case management services are reimbursable under another program, the costs must be allocated between those programs and Medicaid in accordance with OMB Circular No. A-87 or any related or successor guidance or regulations regarding allocation of costs.

(4) The case manager must complete a competency-based training program with content related to knowledge and understanding of eligible children, Early ACCESS rules, the nature and scope of services in Early ACCESS, and the system of payments for services, as well as case management responsibilities and strategies. The department of education or its designee shall determine whether a person has successfully completed the training.

c. Assessment. The case manager shall conduct a comprehensive assessment and periodic reassessment of an eligible child to identify all of the child's service needs, including the need for any medical, educational, social, or other services. Assessment activities are defined to include the following:

(1) Taking the child's history;

(2) Identifying the needs of the child;

(3) Gathering information from other sources, such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the child;

(4) Completing documentation of the information gathered and the assessment results; and

(5) Repeating the assessment every six months to determine whether the child's needs or preferences have changed.

d. Plan of care. The case manager shall develop a plan of care based on the information collected through the assessment or reassessment. The plan of care shall:

(1) Include the child's strengths and preferences;

(2) Consider the child's physical and social environment;

(3) Specify goals of providing services to the child; and

(4) Specify actions to address the child's medical, social, educational, and other service needs. These actions may include activities such as ensuring the active participation of the child and working with the child or the child's authorized health care decision maker and others to develop goals and identify a course of action to respond to the assessed needs of the child.

e. Other service components. Case management must include the following components:

(1) Contacts with the child and family. The case manager shall have face-to-face contact with the child and family within the first 30 days of service and every three months thereafter. In months in which there is no face-to-face contact, a telephone contact between the service coordinator and the family is required.

(2) Referral and related activities to help a child obtain needed services. The case manager shall help to link the child with medical, social, or educational providers or other programs and services that are capable of providing needed services. Referral activities do not include provision of the direct services, program, or activity to which the child has been linked. Referral activities include:

1. Assisting the family in gaining access to the infant and toddler program services and other services identified in the child's plan of care.
2. Assisting the family in identifying available service providers and funding resources and documenting unmet needs and gaps in services.
3. Making referrals to providers for needed services.
4. Scheduling appointments for the child.
5. Facilitating the timely delivery of services.
6. Arranging payment for medical transportation.

(3) Monitoring and follow-up activities. Monitoring activities shall take place at least once annually for the duration of the child's eligibility, but may be conducted as frequently as necessary to ensure that the plan of care is effectively implemented and adequately addresses the needs of the child. Monitoring and follow-up activities may be with the child, family members, providers, or other entities. The purpose of these activities is to help determine:

1. Whether services are being furnished in accordance with the child's plan of care.
2. Whether the services in the plan of care are adequate to meet the needs of the child.
3. Whether there are changes in the needs or status of the child. If there are changes in the child's needs or status, follow-up activities shall include making necessary adjustments to the plan of care and to service arrangements with providers.

(4) Keeping records, including preparing reports, updating the plan of care, making notes about plan activities in the child's record, and preparing and responding to correspondence with the family and others.

f. *Documentation of case management.* For each child receiving case management, case records must document:

(1) The name of the child;
(2) The dates of case management services;
(3) The agency chosen by the family to provide the case management services;
(4) The nature, content, and units of case management services received;
(5) Whether the goals specified in the care plan have been achieved;
(6) Whether the family has declined services in the care plan;
(7) Time lines for providing services and reassessment; and
(8) The need for and occurrences of coordination with case managers of other programs.

78.49(3) *Child's eligibility.* Payable services must be provided to a child under the age of 36 months who is experiencing developmental delay or who has a condition that is known to have a high probability of resulting in developmental delay at a later date.

78.49(4) *Delivery of services.* Services must be delivered directly by the infant and toddler program provider or by a practitioner under contract with the infant and toddler program provider.

78.49(5) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The infant and toddler program provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The infant and toddler program provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services specified on the form.

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

441—78.50(249A) Local education agency services. Subject to the following subrules, payment shall be made for medical services provided by local education agency services providers to Medicaid members under the age of 21.

78.50(1) *Covered services.* Covered services include, but are not limited to, audiology services, behavior services, consultation services, medical transportation, nursing services, nutrition services, occupational therapy services, personal assistance, physical therapy services, psychologist services, speech-language services, social work services, vision services, and school-based clinic visit services.

a. In order to be paid for the administration of a vaccine covered under the Vaccines for Children (VFC) Program, a local education agency must enroll in the VFC program. Payment for the vaccine will be approved only if the VFC program stock has been depleted.

b. Payment for supplies shall be approved when the supplies are incidental to the patient's care, e.g., syringes for injections, and do not exceed $25 per month. Durable medical equipment and other supplies are not covered as local education agency services.

c. To the extent that federal funding is not available under Title XIX of the Social Security Act, payment for transportation between home and school is not a covered service.

78.50(2) *Coordination services.* Rescinded IAB 12/3/08, effective 2/1/09.

78.50(3) *Delivery of services.* Services must be delivered directly by the local education agency services providers or by a practitioner under contract with the local education agency services provider.

78.50(4) *Remission of nonfederal share of costs.* Payment for services shall be made only when the following conditions are met:

a. Rescinded IAB 5/10/06, effective 7/1/06.

b. The local education agency services provider has executed an agreement to remit the nonfederal share of the cost to the department.

c. The local education agency provider shall sign and return Form 470-3816, Medicaid Billing Remittance, along with the funds remitted for the nonfederal share of the costs of the services as specified on the form.

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

[**ARC 0065C**, IAB 4/4/12, effective 6/1/12]

441—78.51(249A) Indian health service 638 facility services. Payment shall be made for all medically necessary services and supplies provided by a licensed practitioner at an Indian health service 638 facility, as defined at rule 441—77.45(249A), within the practitioner's scope of practice and subject to the limitations and exclusions set forth in subrule 78.1(1).

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

441—78.52(249A) HCBS children's mental health waiver services. Payment will be approved for the following services to members eligible for the HCBS children's mental health waiver as established in 441—Chapter 83 and as identified in the member's service plan.

78.52(1) *General service standards.* All children's mental health waiver services must be provided in accordance with the following standards:

a. Reimbursement shall not be available under the waiver for any services that the member can obtain as other nonwaiver Medicaid services or through any other funding source.

b. All services provided under the waiver must be delivered in the least restrictive environment possible and in conformity with the member's service plan.

c. Services must be billed in whole units.

d. For all services with a 15-minute unit of service, the following rounding process will apply:

(1) Add together the minutes spent on all billable activities during a calendar day for a daily total.

(2) For each day, divide the total minutes spent on billable activities by 15 to determine the number of full 15-minute units for that day.

(3) Round the remainder using these guidelines: Round 1 to 7 minutes down to zero units; round 8 to 14 minutes up to one unit.

(4) Add together the number of full units and the number of rounded units to determine the total number of units to bill for that day.

78.52(2) *Environmental modifications and adaptive devices.*

a. Environmental modifications and adaptive devices include medically necessary items installed or used within the member's home that are used by the member to address specific, documented health, mental health, or safety concerns. The following items are excluded under this service:

(1) Items ordinarily covered by Medicaid.

(2) Items funded by educational or vocational rehabilitation programs.

(3) Items provided by voluntary means.

(4) Repair and maintenance of items purchased through the waiver.

(5) Fencing.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the member's case file a signed statement from a mental health professional on the member's interdisciplinary team that the service has a direct relationship to the member's diagnosis of serious emotional disturbance.

d. Payment for most items shall be based on a fee schedule. The amount of the fee shall be determined as directed in 441—subrule 79.1(17).

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

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

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

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

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

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

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

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

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

(6) Developing medication management skills.

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

(8) Developing positive socialization and citizenship skills.

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

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

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

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

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

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

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

(1) Vocational services.

(2) Prevocational services.

(3) Supported employment services.

(4) Room and board.

(5) Academic services.

(6) General supervision and care.

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

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.

a. The goal of in-home family therapy is to maintain a cohesive family unit.

b. In-home family therapy is exclusive of and cannot serve as a substitute for individual therapy, family therapy, or other mental health therapy that may be obtained through the Iowa Plan or other funding sources.

c. A unit of in-home family therapy service is 15 minutes.

78.52(5) *Respite care services.* Respite care services are services provided to the member that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that period. The purpose of respite care is to enable the member to remain in the member's current living situation.

a. Respite services provided outside the member's home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

b. Member-to-staff ratios shall be appropriate to the individual needs of the member as determined by the member's interdisciplinary team.

c. A unit of service is 15 minutes.

d. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care.

e. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in 441—Chapter 83.

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

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

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

This rule is intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11 (See Delay note at end of chapter); **ARC 9704B**, IAB 9/7/11, effective 9/1/11; **ARC 9884B**, IAB 11/30/11, effective 1/4/12; **ARC 0707C**, IAB 5/1/13, effective 7/1/13; **ARC 0709C**, IAB 5/1/13, effective 7/1/13]

441—78.53(249A) Health home services. Subject to federal approval in the Medicaid state plan, payment shall be made for health home services as described in subrule 78.53(1) provided to an eligible Medicaid member as described in subrule 78.53(2) who has selected a health home services provider as provided in subrule 78.53(3).

78.53(1) *Covered services.* Health home services consist of the following services provided in a comprehensive, timely, and high-quality manner using health information technology to link services, as feasible and appropriate:

a. Comprehensive care management, which means:

(1) Providing for all the member's health care needs or taking responsibility for arranging care with other qualified professionals;

(2) Developing and maintaining for each member a continuity of care document that details all important aspects of the member's medical needs, treatment plan, and medication list; and

(3) Implementing a formal screening tool to assess behavioral health treatment needs and physical health care needs.

b. Care coordination, which means assisting members with:

(1) Medication adherence;

(2) Chronic disease management;

(3) Appointments, referral scheduling, and reminders; and

(4) Understanding health insurance coverage.

c. Health promotion, which means coordinating or providing behavior modification interventions aimed at:

(1) Supporting health management;

(2) Improving disease control; and

(3) Enhancing safety, disease prevention, and an overall healthy lifestyle.

d. Comprehensive transitional care following a member's move from an inpatient setting to another setting. Comprehensive transitional care includes:

(1) Updates of the member's continuity of care document and case plan to reflect the member's short-term and long-term care coordination needs; and

(2) Personal follow-up with the member regarding all needed follow-up after the transition.

e. Member and family support (including authorized representatives). This support may include:

(1) Communicating with and advocating for the member or family for the assessment of care decisions;

(2) Assisting with obtaining and adhering to medications and other prescribed treatments;

(3) Increasing health literacy and self-management skills; and

(4) Assessing the member's physical and social environment so that the plan of care incorporates needs, strengths, preferences, and risk factors.

f. Referral to community and social support services available in the community.

78.53(2) *Members eligible for health home services.*

a. Subject to the authority of the Secretary of the United States Department of Health and Human Services pursuant to 42 U.S.C. §1396w-4(h)(1)(B) to establish higher levels for the number or severity of chronic or mental health conditions for purposes of determining eligibility for receipt of health home services, payment shall be made only for health home services provided to a Medicaid member who:

(1) Has at least two chronic conditions;

(2) Has one chronic condition and is at risk of having a second chronic condition;

(3) Has a serious mental illness; or

(4) Has a serious emotional disturbance.

b. For purposes of this rule, the term "chronic condition" means:

(1) A mental health disorder.

(2) A substance use disorder.

(3) Asthma.

(4) Diabetes.

(5) Heart disease.

(6) Being overweight, as evidenced by:
1. Having a body mass index (BMI) over 25 for an adult, or
2. Weighing over the 85th percentile for the pediatric population.
(7) Hypertension.
c. For purposes of this rule, the term "serious mental illness" means:
(1) A psychotic disorder;
(2) Schizophrenia;
(3) Schizoaffective disorder;
(4) Major depression;
(5) Bipolar disorder;
(6) Delusional disorder; or
(7) Obsessive-compulsive disorder.
d. For purposes of this rule, the term "serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder (not including substance use disorders, learning disorders, or intellectual disorders) that is of sufficient duration to meet diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association and that results in a functional impairment. For this purpose, the term "functional impairment" means episodic, recurrent, or continuous difficulties that substantially interfere with or limit a person from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills and that substantially interfere with or limit the person's role or functioning in family, school, or community activities, not including difficulties resulting from temporary and expected responses to stressful events in a person's environment.

78.53(3) *Selection of health home services provider.* As a condition of payment for health home services, the eligible member receiving the services must have selected the billing provider as the member's health home, as reported by the provider. A member must select a provider located in the member's county of residence or in a contiguous county.

This rule is intended to implement Iowa Code section 249A.4 and 2011 Iowa Acts, chapter 129, section 10.
[**ARC 0198C**, IAB 7/11/12, effective 7/1/12; **ARC 0838C**, IAB 7/24/13, effective 7/1/13]

441—78.54(249A) Speech-language pathology services. Payment will be approved for the same services provided by a speech-language pathologist that are payable under Title XVIII of the Social Security Act (Medicare).

This rule is intended to implement Iowa Code section 249A.4 and 2012 Iowa Acts, Senate File 2158.
[**ARC 0360C**, IAB 10/3/12, effective 12/1/12]

441—78.55(249A) Services rendered via telehealth. An in-person contact between a health care professional and a patient is not required as a prerequisite for payment for otherwise-covered services appropriately provided through telehealth in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the services are provided, as well as being in accordance with provisions under rule 653—13.11(147,148,272C). Health care services provided through in-person consultations or through telehealth shall be treated as equivalent services for the purposes of reimbursement.

This rule is intended to implement Iowa Code section 249A.4 and 2015 Iowa Acts, Senate File 505, division V, section 12(23).
[**ARC 2166C**, IAB 9/30/15, effective 11/4/15]

441—78.56(249A) Community-based neurobehavioral rehabilitation services. Payment will be made for community-based neurobehavioral rehabilitation services that do not duplicate other services covered in this chapter.

78.56(1) *Definitions.*

"Assessment" means the review of the current functioning of the member using the service in regard to the member's situation, needs, strengths, abilities, desires, and goals.

"Brain injury" means a diagnosis in accordance with rule 441—83.81(249A).

"Health care" means the services provided by trained and licensed health care professionals to restore or maintain the member's health.

"Intermittent community-based neurobehavioral rehabilitation services" are provided to a Medicaid member on an as-needed basis to support the member and the member's family or caregivers to assist the member to increase adaptive behaviors, decrease maladaptive behaviors, and adapt and accommodate to challenging behaviors to support the member to remain in the member's own home and community.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Neurobehavioral rehabilitation" refers to a specialized category of neurorehabilitation provided by a multidisciplinary team that has been trained in, and delivers, services individually designed to address cognitive, medical, behavioral and psychosocial challenges, as well as the physical manifestations of acquired brain injury. Services concurrently work to optimize functioning at personal, family and community levels, by supporting the increase of adaptive behaviors, decrease of maladaptive behaviors and adaptation and accommodation to challenging behaviors to support a member to maximize the member's independence in activities of daily living and ability to live in the member's home and community.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals for eligible members.

"Standardized assessment" means a valid, reliable, and comprehensive functional assessment tool(s) or process, or both, approved by the department for use in the assessment of a member's individual needs.

78.56(2) *Member eligibility.* To be eligible to receive community-based neurobehavioral rehabilitation services, a member shall meet the following criteria:

a. Brain injury diagnosis. To be eligible for community-based neurobehavioral rehabilitation services, the member must have a brain injury diagnosis as set forth in rule 441—83.81(249A).

b. Risk factors. The member has the following post-brain injury risk factors:

(1) The member is exhibiting neurobehavioral symptoms in such frequency or severity that the member has undergone or is currently undergoing treatment more intensive than outpatient care and is currently hospitalized, institutionalized, incarcerated or homeless or is at risk of hospitalization, institutionalization, incarceration or homelessness; or

(2) The member has a history of presenting with neurobehavioral or psychiatric symptoms resulting in at least one episode that required professional supportive care more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).

c. Need for assistance. The member exhibits neurobehavioral symptoms in such frequency, severity or intensity that community-based neurobehavioral rehabilitation is required.

d. Needs assessment. The member shall have a standardized comprehensive functional neurobehavioral assessment reviewed or completed by a licensed neuropsychologist, neurologist, M.D., or D.O. The neurobehavioral assessment shall document the member's need for community-based neurobehavioral rehabilitation, and the medical services unit of the Iowa Medicaid enterprise has determined that the member is in need of specialty neurobehavioral rehabilitation services.

e. Standards for assessment. Each member will have had a department-approved, standardized comprehensive functional neurobehavioral assessment completed within the 90 days prior to admission. Each needs assessment will include the assessment of a member's individual physical, emotional, cognitive, medical and psychosocial residuals related to the member's brain injury, which must include the following:

(1) Identification of the neurobehavioral needs that put the member at risk, including but not limited to verbal aggression, physical aggression, self-harm, unwanted sexual behavior, cognitive and or behavioral perseveration, wandering or elopement, lack of motivation, lack of initiation or other unwanted social behaviors not otherwise specified.

(2) Identification of triggers of unwanted behaviors and the member's ability to self-manage the member's symptoms.

(3) The member's rehabilitation and medical care history to include medication history and status.

(4) The member's employment history and the member's barriers to employment.

(5) The member's dietary and nutritional needs.

(6) The member's community accessibility and safety.

(7) The member's access to transportation.

(8) The member's history of substance abuse.

(9) The member's vulnerability to exploitation and history of risk of exploitation.

(10) The member's history and status of relationships, natural supports and socialization.

f. *Emergency admission.* In the event that emergency admission is required, the assessment shall be completed within ten calendar days of admission.

78.56(3) *Covered services.*

a. Service setting.

(1) Community-based neurobehavioral residential rehabilitation services are provided to a member living in a three-to-five-bed residential care facility with a specialized license designation issued by the department of inspections and appeals; or

(2) Community-based neurobehavioral intermittent rehabilitation services are provided to a member living in the member's own residence in the community.

No payment shall be made for community-based neurobehavioral rehabilitation when provided in a medical institution such as an intermediate care facility for persons with intellectual disabilities, nursing facility or skilled nursing facility.

b. Community-based neurobehavioral rehabilitation residential services identified in the treatment plan may include:

(1) Prescriptive programming to maintain and advance progress made in rehabilitation;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Assistance in obtaining preventative, appropriate and timely medical and dental care;

(4) Compensatory strategies to assist in managing ADLS (activities of daily living);

(5) Assistance with coordinating and obtaining physical, oral, or mental health care and any other professional services necessary to the member's health and well-being;

(6) Behavioral and cognitive programming and supports;

(7) Medication management and consultation with pharmacy;

(8) Health and wellness management including dietary and nutritional programming;

(9) Progressive physical strengthening, fitness and retraining;

(10) Assistance with obtaining and use of assistive technology;

(11) Sobriety support development;

(12) Assistance with the self-identification of antecedent triggers;

(13) Assistance with preparation for transition to less intensive services including accessing the community;

(14) Flexibility in programming to meet individual needs;

(15) Assistance with re-learning coping and compensatory strategies;

(16) Support and assistance in seeking substance abuse and co-occurring disorders services;

(17) Support and assistance with obtaining legal consultation and services;

(18) Assistance with community accessibility and safety;

(19) Assistance with re-learning household maintenance;

(20) Assistance with recreational and leisure skill development;

(21) Assistance with the development and application of self-advocacy skills to navigate the service system;

(22) Opportunities to learn about brain injury and individual needs following brain injury;

(23) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(24) Assistance with pursuit of education and employment goals;

(25) Protective oversight in the residential setting and community;

(26) Assistance and education to family, providers and other support system interests that are supporting the member receiving neurobehavioral rehabilitation services;

(27) Transitional support and training;

(28) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan;

(29) Promotion of a program structure and support for members served so they can relearn or regain skills for maximum independence, community access, and integration.

c. Community-based neurobehavioral rehabilitation intermittent services identified in the treatment plan may occur in the member's own home with or on behalf of the member and may include:

(1) Promotion of a program structure and support for members served so they can re-learn or regain skills for maximum community inclusion and access;

(2) Modifying or adapting the member's environment to improve overall functioning;

(3) Compensatory strategies to assist in managing ADLS (activities of daily living);

(4) Behavioral supports;

(5) Assistance with obtaining and use of assistive technology;

(6) Assistance with the self-identification of antecedent triggers;

(7) Flexibility in programming to meet the member's individual needs;

(8) Assistance with re-learning coping and compensatory strategies;

(9) Assistance with the development and application of self-advocacy skills to navigate the service system;

(10) Support for carrying out the member's individual goals in the rehabilitation treatment plan;

(11) Assistance and education to family, providers and other support system interests that are supporting the member receiving community-based neurobehavioral rehabilitation services;

(12) Transitional support and training;

(13) Transportation essential to the attainment of the member's individual goals in the rehabilitation treatment plan.

d. Approval of treatment plan. The community-based neurobehavioral services provider shall submit the proposed plan of care, the results of the member's formal assessment, and medical documentation supporting a brain injury diagnosis to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

e. Initial treatment plan. Within 30 days of admission, the provider shall submit the member's treatment plan to the IME medical services unit.

(1) The IME medical services unit will approve the provider's treatment plan if:

1. The treatment plan conforms to the medical necessity requirements in subrule 78.55(4);

2. The treatment plan is consistent with the written diagnosis and treatment recommendations made by a licensed medical professional that is a licensed neuropsychologist or neurologist, M.D., or D.O.;

3. The treatment plan is sufficient in amount, duration, and scope to reasonably achieve its purpose;

4. The provider can demonstrate that the provider possesses the skills and resources necessary to implement the plan; and

5. The treatment plan does not exceed 180 days in duration.

(2) A treatment summary detailing the member's response to treatment during the previous approval period must be submitted when approval for subsequent plans is requested.

f. Subsequent plans. The IME medical services unit may approve a subsequent neurobehavioral rehabilitation treatment plan that conforms to the conditions of medical necessity pursuant to subrule 78.56(4) and to the conditions pursuant to subrule 78.56(3).

g. Quality review. The IME medical services unit may perform the quality review to evaluate:

(1) The time elapsed from referral to rehabilitation treatment plan development;

(2) The continuity of treatment;

(3) The length of stay per member;

(4) The affiliation of the medical professional recommending services with the neurobehavioral rehabilitation services provider;

(5) Gaps in service;

(6) The results achieved;

(7) Member and stakeholder satisfaction;

(8) The provider's compliance with standards listed in rule 441—77.54(249A).

78.56(4) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of community-based neurobehavioral rehabilitation services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

78.56(5) *Documentation standards.* Community-based neurobehavioral rehabilitation service providers shall maintain service provision records, financial records, and clinical records in accordance with the provisions of rule 441—79.3(249A).

[**ARC 2341C**, IAB 1/6/16, effective 2/10/16]

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

78.57(1) Nursing services are services which are provided by a registered nurse or a licensed practical nurse under the direction of the member's physician to a member in a licensed child care center. Nursing services shall be provided according to a written plan of care authorized by a physician. Payment for nursing services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Nursing services include activities that require the expertise of a nurse, such as physical assessment, tracheostomy care, medication administration, and tube feedings.

78.57(2) Personal care services are those services which are provided by an aide but are delegated and supervised by a registered nurse under the direction of the member's physician. Payment for personal care services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Personal care services shall be in accordance with the member's plan of care and authorized by a physician. Personal care services include the activities of daily living, oral hygiene, grooming, toileting, feeding, range of motion and positioning, and training the member in necessary self-help skills, including teaching prosocial skills and reinforcing positive interactions.

78.57(3) Psychosocial services are those services that focus at decreasing or eliminating maladaptive behaviors. Payment for psychosocial services may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Psychosocial services shall be in accordance with the member's plan of care and authorized by a physician. Psychosocial services include implementing a plan using clinically accepted techniques for decreasing or eliminating maladaptive behaviors. Psychosocial intervention plans must be developed and reviewed by licensed mental health providers.

78.57(4) Developmental therapies are those services which are provided by an aide but are delegated and supervised by a licensed therapist under the direction of the member's physician. Payment for developmental therapies may be approved if the services are determined to be medically necessary as defined in subrule 78.57(5). Developmental therapies shall be in accordance with the member's plan of care and authorized by a physician. Developmental therapies include activities based on the individual's needs such as fine motor, gross motor, and receptive expressive language.

78.57(5) "Medically necessary" means the service is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that endanger life, cause pain, result in illness or infirmity, or threaten to cause or aggravate a disability or chronic illness and is an effective course of treatment for the member requesting a service.

78.57(6) Requirements.

a. Nursing, psychosocial, developmental therapies and personal care services shall be ordered in writing.

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

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

(1) Place of service.

(2) Type of service to be rendered and the treatment modalities being used.

(3) Frequency of the services.

(4) Assistance devices to be used.

(5) Date on which services were initiated.

(6) Progress of member in response to treatment.

(7) Medical supplies to be furnished.

(8) Member's medical condition as reflected by the following information, if applicable:

1. Dates of prior hospitalization.
2. Dates of prior surgery.
3. Date last seen by a primary care provider.
4. Diagnoses and dates of onset of diagnoses for which treatment is being rendered.
5. Prognosis.
6. Functional limitations.
7. Vital signs reading.
8. Date of last episode of acute recurrence of illness or symptoms.
9. Medications.

(9) Discipline of the person providing the service.

(10) Certification period.

(11) Physician's signature and date. The treatment plan must be signed and dated by the physician before the claim for service is submitted for reimbursement.

(12) Forms 470-4815 and 470-4816 are utilized during the prior authorization review.

78.57(7) Nursing, personal care, and psychosocial services do not include:

a. Services provided to members aged 21 and older.

b. Services that require prior authorizations that are provided without regard to the prior authorization process.

c. Nursing services provided simultaneously with other Medicaid services (e.g., home health aide, physical, occupational, or speech therapy services, etc.).

d. Services that exceed the services that are approvable under the private duty nursing and personal care program pursuant to subrule 78.9(10).

e. Transportation services.

f. Services provided to a member while the member is in institutional care.

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

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

[Filed 3/11/70; amended 3/20/74]
[Filed 11/25/75, Notice 10/6/75—published 12/15/75, effective 1/19/76]
[Filed emergency 12/23/75—published 1/12/76, effective 2/1/76]
[Filed emergency 1/16/76—published 2/9/76, effective 2/1/76]
[Filed emergency 1/29/76—published 2/9/76, effective 1/29/76]
[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]
[Filed emergency 6/9/76—published 6/28/76, effective 6/9/76]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed emergency 12/17/76—published 1/12/77, effective 1/1/77]
[Filed 2/25/77, Notice 1/12/77—published 3/23/77, effective 4/27/77]
[Filed emergency 4/13/77—published 5/4/77, effective 4/13/77]
[Filed emergency 7/20/77—published 8/10/77, effective 7/20/77]
[Filed emergency 8/24/77—published 9/21/77, effective 8/26/77]
[Filed emergency 9/1/77—published 9/21/77, effective 9/1/77]
[Filed 11/22/77, Notice 9/7/77—published 12/14/77, effective 2/1/78]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
[Filed 3/27/78, Notice 2/8/78—published 4/19/78, effective 5/24/78]
[Filed without Notice 3/31/78—published 4/19/78, effective 7/1/78]
[Filed emergency 6/9/78—published 6/28/78, effective 7/5/78]
[Filed emergency 6/28/78—published 7/26/78, effective 7/1/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed 8/18/78, Notice 5/31/78—published 9/6/78, effective 10/11/78]
[Filed 9/12/78, Notice 4/19/78—published 10/4/78, effective 11/8/78]
[Filed 9/12/78, Notice 7/26/78—published 10/4/78, effective 12/1/78]
[Filed 11/20/78, Notice 10/4/78—published 12/13/78, effective 1/17/79]
[Filed 12/6/78, Notice 10/4/78—published 12/27/78, effective 2/1/79]
[Filed 12/6/78, Notice 5/31/78—published 12/27/78, effective 2/1/79]
[Filed 1/4/79, Notice 11/29/78—published 1/24/79, effective 3/1/79]
[Filed emergency 1/31/79—published 2/21/79, effective 3/8/79]
[Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 6/1/79]
[Filed 7/3/79, Notice 4/18/79—published 7/25/79, effective 8/29/79]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79]
[Filed emergency 9/6/79 after Notice 7/11/79—published 10/3/79, effective 10/1/79]
[Filed 10/24/79, Notice 5/30/79—published 11/14/79, effective 12/19/79]
[Filed 10/24/79, Notice 8/22/79—published 11/14/79, effective 12/19/79]
[Filed emergency 1/23/80—published 2/20/80, effective 1/23/80]
[Filed 4/4/80, Notice 1/23/80—published 4/30/80, effective 6/4/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed emergency 7/3/80—published 7/23/80, effective 7/8/80 to 1/1/81]
[Filed 7/3/80, Notice 4/14/80—published 7/23/80, effective 8/27/80]
[Filed 9/25/80, Notice 8/6/80—published 10/15/80, effective 11/19/80]
[Filed without Notice 9/26/80—published 10/15/80, effective 12/1/80]
[Filed 10/23/80, Notice 7/23/80—published 11/12/80, effective 12/17/80]
[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
[Filed 12/19/80, Notices 10/15/80, 10/29/80—published 1/7/81, effective 2/11/81]
[Filed emergency 1/20/81—published 2/18/81, effective 1/20/81]
[Filed 2/12/81, Notice 11/12/80—published 3/4/81, effective 7/1/81]
[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed emergency 8/24/81 after Notice 7/8/81—published 9/16/81, effective 9/1/81]

[Filed 10/23/81, Notice 9/2/81—published 11/11/81, effective 1/1/82]
[Filed emergency 12/3/81—published 12/23/81, effective 1/1/82]
[Filed 1/28/82, Notice 10/28/81—published 2/17/82, effective 4/1/82]
[Filed 1/28/82, Notice 11/25/81—published 2/17/82, effective 4/1/82]
[Filed 2/26/82, Notice 10/14/81—published 3/17/82, effective 5/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed 4/5/82, Notice 1/20/82—published 4/28/82, effective 6/2/82]
[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
[Filed 7/30/82, Notices 3/3/82, 4/28/82—published 8/18/82, effective 10/1/82]
[Filed emergency 9/23/82 after Notice 6/23/82—published 10/13/82, effective 10/1/82]
[Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
[Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
[Filed 5/20/83, Notices 3/30/83, 4/13/83—published 6/8/83, effective 8/1/83][1 7 10]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 7/29/83—published 8/17/83, effective 8/1/83][1 7 10]
[Filed 7/29/83, Notice 5/25/83—published 8/17/83, effective 10/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 10/28/83, Notices 8/31/83, 9/14/83—published 11/23/83, effective 1/1/84][1 7 10]
[Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 5/4/84, Notice 3/14/84—published 5/23/84, effective 7/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 11/1/84, Notice 9/12/84—published 11/21/84, effective 1/1/85]
[Filed 12/11/84, Notice 10/10/84—published 1/2/85, effective 3/1/85]
[Filed 1/21/85, Notice 10/24/84—published 2/13/85, effective 4/1/85]
[Filed 4/29/85, Notice 12/19/84—published 5/22/85, effective 7/1/85]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 5/29/85, Notice 3/27/85—published 6/19/85, effective 8/1/85]
[Filed emergency 8/23/85—published 9/11/85, effective 9/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed emergency 10/18/85 after Notice 9/11/85—published 11/6/85, effective 11/1/85]
[Filed 11/15/85, Notice 9/25/85—published 12/4/85, effective 2/1/86]
[Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed 2/21/86, Notices 12/18/85, 1/1/86, 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 9/26/86, Notice 8/13/86—published 10/22/86, effective 12/1/86]
[Filed emergency 12/22/86—published 1/14/87, effective 2/1/87]
[Filed 12/22/86, Notice 11/5/86—published 1/14/87, effective 3/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notices 12/17/86, 12/31/86, 1/14/87—published 3/25/87, effective 5/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed 5/29/87, Notices 4/8/87, 4/22/87—published 6/17/87, effective 8/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 6/19/87, Notice 5/6/87—published 7/15/87, effective 9/1/87]
[Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]

[Filed 8/28/87, Notices 6/17/87, 7/15/87—published 9/23/87, effective 11/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88][2]
[Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
[Filed emergency 11/16/88 after Notice 10/5/88—published 12/14/88, effective 1/1/89]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
[Filed 12/8/88, Notice 10/19/88—published 12/28/88, effective 2/1/89]
[Filed 3/15/89, Notice 2/8/89—published 4/5/89, effective 6/1/89]
[Filed emergency 6/8/89 after Notice 2/22/89—published 6/28/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed 10/11/89, Notice 8/23/89—published 11/1/89, effective 1/1/90]
[Filed 11/16/89, Notice 8/23/89—published 12/13/89, effective 2/1/90]
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 1/17/90, Notice 8/23/89—published 2/7/90, effective 4/1/90][3]
[Filed emergency 2/14/90—published 3/7/90, effective 2/14/90]
[Filed 3/16/90, Notices 11/15/89, 1/24/90, 2/7/90—published 4/4/90, effective 6/1/90]
[Filed 4/13/90, Notice 3/7/90—published 5/2/90, effective 7/1/90]
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
[Filed 7/13/90, Notices 5/16/90, 5/30/90—published 8/8/90, effective 10/1/90]
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
[Filed 9/28/90, Notices 7/11/90, 7/25/90, 8/8/90—published 10/17/90, effective 12/1/90]
[Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed 11/16/90, Notices 9/19/90, 10/3/90—published 12/12/90, effective 2/1/91]
[Filed 12/13/90, Notice 10/31/90—published 1/9/91, effective 3/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91][4]
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 4/11/91, Notice 3/6/91—published 5/1/91, effective 7/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed 6/14/91, Notice 3/20/91—published 7/10/91, effective 9/1/91]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92][5]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
[Filed emergency 7/17/92—published 8/5/92, effective 8/1/92]
[Filed 7/17/92, Notices 5/27/92—published 8/5/92, effective 10/1/92][1 7 10]
[Filed emergency 8/14/92—published 9/2/92, effective 9/1/92]
[Filed 8/14/92, Notices 6/24/92, 7/8/92, 8/5/92—published 9/2/92, effective 11/1/92]

[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 9/11/92, Notices 7/8/92, 8/5/92—published 9/30/92, effective 12/1/92]
[Filed 9/11/92, Notice 8/5/92—published 9/30/92, effective 1/1/93]
[Filed 10/15/92, Notices 8/19/92, 9/2/92—published 11/11/92, effective 1/1/93]
[Filed emergency 11/10/92—published 12/9/92, effective 11/10/92]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed 1/14/93, Notices 10/28/92, 11/25/92—published 2/3/93, effective 4/1/93]
[Filed emergency 4/15/93 after Notice 3/3/93—published 5/12/93, effective 5/1/93]
[Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
[Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
[Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed emergency 7/14/93—published 8/4/93, effective 8/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notice 7/7/93—published 9/1/93, effective 11/1/93]
[Filed 9/17/93, Notice 8/4/93—published 10/13/93, effective 12/1/93]
[Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
[Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
[Filed emergency 12/16/93 after Notice 10/13/93—published 1/5/94, effective 1/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
[Filed emergency 2/10/94 after Notice 12/22/93—published 3/2/94, effective 3/1/94]
[Filed 3/10/94, Notice 2/2/94—published 3/30/94, effective 6/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 6/22/94—published 8/31/94, effective 11/1/94]
[Filed 9/15/94, Notices 7/6/94, 8/3/94—published 10/12/94, effective 12/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/5/95]
[Filed 5/11/95, Notices 3/29/95—published 6/7/95, effective 8/1/95]
[Filed 6/7/95, Notice 4/26/95—published 7/5/95, effective 9/1/95]
[Filed 6/14/95, Notice 5/10/95—published 7/5/95, effective 9/1/95]
[Filed 10/12/95, Notice 8/30/95—published 11/8/95, effective 1/1/96]
[Filed 11/16/95, Notices 8/2/95, 9/27/95[6]—published 12/6/95, effective 2/1/96]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
[Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
[Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
[Filed 1/15/97, Notice 12/4/96—published 2/12/97, effective 4/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 7/9/97, Notice 5/21/97—published 7/30/97, effective 10/1/97]
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 1/14/98, Notice 11/19/97—published 2/11/98, effective 4/1/98]
[Filed 4/8/98, Notices 2/11/98, 2/25/98—published 5/6/98, effective 7/1/98]
[Filed 5/13/98, Notice 3/25/98—published 6/3/98, effective 8/1/98]

[Filed emergency 6/10/98—published 7/1/98, effective 6/10/98]
[Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
[Filed 10/14/98, Notice 7/1/98—published 11/4/98, effective 12/9/98]
[Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 3/1/99]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed 3/10/99, Notice 1/27/99—published 4/7/99, effective 6/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 10/13/99, Notice 6/30/99—published 11/3/99, effective 1/1/00]
[Filed 4/12/00, Notice 2/23/00—published 5/3/00, effective 7/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed 6/8/00, Notices 1/26/00, 4/19/00—published 6/28/00, effective 9/1/00]
[Filed 8/9/00, Notices 6/14/00, 6/28/00—published 9/6/00, effective 11/1/00]
[Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed 10/11/00, Notice 4/19/00—published 11/1/00, effective 1/1/01]
[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
[Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 7/4/01]
[Filed 5/9/01, Notices 1/24/01, 3/7/01—published 5/30/01, effective 8/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01][1 7 10]
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
[Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
[Filed 11/14/01, Notices 9/19/01, 10/3/01—published 12/12/01, effective 2/1/02]
[Filed emergency 12/12/01 after Notice 10/17/01—published 1/9/02, effective 12/12/01]
[Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
[Filed 12/12/01, Notice 10/17/01—published 1/9/02, effective 3/1/02][1 7 10]
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02][1 7 10]
[Filed emergency 1/16/02—published 2/6/02, effective 2/1/02][8]
[Filed emergency 2/14/02—published 3/6/02, effective 3/1/02]
[Filed 3/13/02, Notice 1/9/02—published 4/3/02, effective 6/1/02]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
[Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
[Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
[Filed 4/10/02, Notice 3/6/02—published 5/1/02, effective 7/1/02]
[Filed emergency 7/11/02—published 8/7/02, effective 7/11/02]
[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
[Filed emergency 8/15/02—published 9/4/02, effective 9/1/02]
[Filed 9/12/02, Notice 8/7/02—published 10/2/02, effective 12/1/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/15/02][9]
[Filed 11/18/02, Notice 9/4/02—published 12/11/02, effective 2/1/03]
[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
[Filed 12/12/02, Notice 10/30/02—published 1/8/03, effective 3/1/03]
[Filed emergency 1/9/03—published 2/5/03, effective 2/1/03][1 7 10]

[Filed 2/13/03, Notice 11/27/02—published 3/5/03, effective 5/1/03]
[Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03][1 7 10]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03][1 7 10]
[Filed emergency 11/19/03—published 12/10/03, effective 1/1/04]
[Filed 1/16/04, Notices 9/17/03, 10/29/03—published 2/4/04, effective 3/10/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04][1 7 10]
[Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed 7/15/05, Notice 5/25/05—published 8/3/05, effective 10/1/05]
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed emergency 10/21/05—published 11/9/05, effective 11/1/05]
[Filed 10/21/05, Notices 5/11/05 and 7/6/05—published 11/9/05, effective 12/14/05][1 7 10]
[Filed 10/21/05, Notice 8/31/05—published 11/9/05, effective 1/1/06]
[Filed 1/12/06, Notice 11/9/05—published 2/1/06, effective 3/8/06]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
[Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
[Filed 5/12/06, Notice 3/15/06—published 6/7/06, effective 8/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
[Filed 10/20/06, Notice 8/2/06—published 11/8/06, effective 1/1/07]
[Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
[Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
[Filed emergency 3/14/07 after Notice 1/17/07—published 4/11/07, effective 4/1/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed emergency 7/12/07—published 8/1/07, effective 7/12/07]
[Filed emergency 7/12/07 after Notice 5/23/07—published 8/1/07, effective 8/1/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
[Filed without Notice 7/20/07—published 8/15/07, effective 10/1/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
[Filed emergency 9/12/07 after Notice 7/18/07—published 10/10/07, effective 10/1/07]
[Filed emergency 1/9/08 after Notice 10/10/07—published 1/30/08, effective 2/1/08]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 5/15/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
[Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
[Filed 6/11/08, Notice 4/23/08—published 7/2/08, effective 9/1/08]
[Filed emergency 8/18/08—published 9/10/08, effective 9/1/08]
[Filed emergency 8/18/08 after Notice 7/2/08—published 9/10/08, effective 10/1/08]
[Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
[Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
[Filed 10/14/08, Notice 8/13/08—published 11/5/08, effective 1/1/09]
[Filed emergency 11/12/08 after Notice 9/10/08—published 12/3/08, effective 12/1/08]
[Filed 11/12/08, Notice 9/24/08—published 12/3/08, effective 2/1/09]
[Filed 12/11/08, Notice 9/10/08—published 1/14/09, effective 2/18/09]
[Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]

[Filed ARC 7548B (Notice ARC 7369B, IAB 11/19/08), IAB 2/11/09, effective 4/1/09]
[Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09][11]
[Filed Emergency After Notice ARC 8008B (Notice ARC 7771B, IAB 5/20/09), IAB 7/29/09, effective 8/1/09]
[Filed ARC 8097B (Notice ARC 7816B, IAB 6/3/09), IAB 9/9/09, effective 11/1/09]
[Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
[Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
[Filed ARC 8504B (Notice ARC 8247B, IAB 10/21/09), IAB 2/10/10, effective 3/22/10]
[Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
[Filed Emergency After Notice ARC 8714B (Notice ARC 8538B, IAB 2/24/10), IAB 5/5/10, effective 5/1/10]
[Filed ARC 8993B (Notice ARC 8722B, IAB 5/5/10), IAB 8/11/10, effective 10/1/10]
[Filed ARC 8994B (Notice ARC 8756B, IAB 5/19/10), IAB 8/11/10, effective 10/1/10]
[Filed ARC 9045B (Notice ARC 8832B, IAB 6/2/10), IAB 9/8/10, effective 11/1/10]
[Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
[Filed ARC 9175B (Notice ARC 8975B, IAB 7/28/10), IAB 11/3/10, effective 1/1/11]
[Filed Emergency ARC 9256B, IAB 12/1/10, effective 1/1/11]
[Filed Emergency ARC 9311B, IAB 12/29/10, effective 1/1/11]
[Filed ARC 9315B (Notice ARC 9111B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
[Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11][12]
[Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
[Editorial change: IAC Supplement 4/20/11]
[Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]
[Filed Emergency After Notice ARC 9649B (Notice ARC 9538B, IAB 6/1/11), IAB 8/10/11, effective 8/1/11]
[Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]
[Filed Emergency ARC 9699B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9702B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9834B, IAB 11/2/11, effective 11/1/11]
[Filed ARC 9882B (Notice ARC 9700B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9883B (Notice ARC 9703B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9981B (Notice ARC 9835B, IAB 11/2/11), IAB 2/8/12, effective 3/14/12]
[Filed ARC 0065C (Notice ARC 9940B, IAB 12/28/11), IAB 4/4/12, effective 6/1/12]
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]
[Filed ARC 0305C (Notice ARC 0144C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]
[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]

[Filed ARC 0631C (Notice ARC 0497C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
[Filed ARC 0632C (Notice ARC 0496C, IAB 12/12/12), IAB 3/6/13, effective 5/1/13]
[Filed ARC 0707C (Notice ARC 0567C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0709C (Notice ARC 0589C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
[Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]
[Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0844C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0846C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
[Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
[Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
[Filed ARC 1052C (Notice ARC 0845C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1054C (Notice ARC 0843C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1151C (Notice ARC 0920C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1264C (Notice ARC 1161C, IAB 10/30/13), IAB 1/8/14, effective 3/1/14]
[Filed ARC 1297C (Notice ARC 1185C, IAB 11/13/13), IAB 2/5/14, effective 4/1/14]
[Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]
[Filed ARC 1696C (Notice ARC 1620C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
[Filed ARC 1850C (Notice ARC 1729C, IAB 11/12/14), IAB 2/4/15, effective 4/1/15]
[Filed ARC 1976C (Notice ARC 1901C, IAB 3/4/15), IAB 4/29/15, effective 7/1/15]
[Filed Emergency After Notice ARC 2050C (Notice ARC 1982C, IAB 4/29/15), IAB 7/8/15, effective 7/1/15]
[Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
[Filed ARC 2166C (Notice ARC 2096C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 2340C (Notice ARC 2115C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
[Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
[Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
[Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
[Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
[Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
[Filed ARC 3005C (Notice ARC 2897C, IAB 1/18/17), IAB 3/29/17, effective 5/3/17]
[Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]

[1] Two ARCs
[2] Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.
[3] Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.
[4] Effective date of 4/1/91 delayed until adjournment of the 1991 session of the General Assembly by the Administrative Rules Review Committee at its meeting held February 12, 1991.
[5] Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
[6] Two ARCs
[7] Two ARCs

[8] At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.

[9] Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.

[10] Two or more ARCs

[11] July 1, 2009, effective date of amendments to 78.27(2)*"d"* delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.

[12] May 11, 2011, effective date of 78.34(5)*"d,"* 78.38(5)*"h,"* 78.41(2)*"g,"* 78.43(3)*"d,"* and 78.52(5)*"a"* delayed 70 days by the Administrative Rules Review Committee at its meeting held April 11, 2011.

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.

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

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 facilities.

(1) Indian health facilities enrolled pursuant to rule 441—77.45(249A) are paid for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible at the current daily visit rates approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register. For services provided to American Indians or Alaskan natives, Indian health facilities may bill for one visit per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all medical services provided on that day, except as follows:

1. For services provided to American Indians and Alaskan natives, Indian health facilities may bill for multiple visits per patient per calendar day for medical services (at the "outpatient per visit rate (excluding Medicare)") only if medical services are provided for different diagnoses or if distinctly different medical services from different categories of services are provided for the same diagnoses in

different units of the facility. For this purpose, the categories of medical services are vision services; dental services; mental health and addiction services; early and periodic screening, diagnosis, and treatment services for children; other outpatient services; and other inpatient services. A visit is a face-to-face contact between a patient and a health professional at or through the facility.

2. For services provided to American Indians or Alaskan natives, Indian health facilities may also bill for one visit per patient per calendar day for outpatient prescribed drugs provided by the facility (at the "outpatient per visit rate (excluding Medicare)"), which shall constitute payment in full for all outpatient prescribed drugs provided on that day.

(2) Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the reimbursement rate otherwise allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form or through pharmacy point of sale. Claims for nonpharmacy 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.*

Provider category	Basis of reimbursement	Upper limit
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	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%.
Child care medical services	Fee schedule	Fee schedule in effect 1/1/16.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community-based neurobehavioral rehabilitation services	Fee schedule, see 79.1(28)	Residential: Limit in effect as of June 30 each year plus CPI-U for the preceding 12-month period ending June 30. Intermittent: $21.11 per 15-minute unit.
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.

Provider category	Basis of reimbursement	Upper limit
Dentists	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Drug and alcohol services	Fee schedule	Fee schedule in effect 1/1/16.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/13 plus 1%.
Emergency psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/13 plus 1%.
Federally qualified health centers	Retrospective cost-related. See 441—Chapter 73	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.
1. Adult day care	Fee schedule	Effective 7/1/16, for AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate: Veterans Administration contract rate or $1.47 per 15-minute unit, $23.47 per half day, $46.72 per full day, or $70.06 per extended day if no Veterans Administration contract. Effective 7/1/16, for intellectual disability waiver: County contract rate or, in the absence of a contract rate, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute, half-day, full-day, or extended-day rate. If no 6/30/16 rate, $1.96 per 15-minute unit, $31.27 per half day, $62.42 per full day, or $79.59 per extended day.

Provider category	Basis of reimbursement	Upper limit
2. Emergency response system:		
Personal response system	Fee schedule	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.
Portable locator system	Fee schedule	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.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and health and disability waivers effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%. For intellectual disability waiver effective 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1% or maximum Medicaid rate in effect 6/30/16 plus 1%, 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	Fee schedule	For AIDS/HIV, health and disability, elderly and intellectual disability waiver effective 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: $87.99 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 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed $315.09 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, not to exceed $315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.
Home care agency:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $8.96 per 15-minute unit, not to exceed $315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $4.78 per 15-minute unit, not to exceed $315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.
Nonfacility care:		
Specialized respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $8.96 per 15-minute unit, not to exceed $315.09 per day.
Basic individual respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $4.78 per 15-minute unit, not to exceed $315.09 per day.
Group respite	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.

Provider category	Basis of reimbursement	Upper limit
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed the facility's daily Medicaid rate.
Camps	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed $315.09 per day.
Adult day care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 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 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 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 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit, not to exceed contractual daily rate.

Provider category	Basis of reimbursement	Upper limit
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.
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 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 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 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $8.76 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 7/1/16 for non-county contract: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $1.89 per 15-minute unit.
15. Consumer-directed attendant care provided by:		

Provider category	Basis of reimbursement	Upper limit
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $5.35 per 15-minute unit, not to exceed $123.85 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $5.35 per 15-minute unit, not to exceed $123.85 per day.
Individual	Fee agreed upon by member and provider	Effective 7/1/16, $3.58 per 15-minute unit, not to exceed $83.36 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 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $11.45 per 15-minute unit.
Group	Fee schedule	Effective 7/1/6, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $11.44 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 7/1/16: $9.28 per 15-minute unit, not to exceed the maximum daily ICF/ID rate per day plus 3.927%.
19. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.

Provider category	Basis of reimbursement	Upper limit
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.
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 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: $11.45 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $11.44 per 15-minute unit.
23. Prevocational services, including career exploration	Fee schedule	Fee schedule in effect 7/1/16.
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 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, 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 7/1/16: Lesser of maximum Medicare rate in effect 6/30/16 plus 1%, converted to a 15-minute rate, or maximum Medicaid rate in effect 6/30/16 plus 1%, converted to a 15-minute rate.
Child development home or center	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $3.49 per 15-minute unit.
Supported community living provider	Retrospectively limited prospective rate. See 79.1(15)	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $9.28 per 15-minute unit, not to exceed the maximum ICF/ID rate per day plus 3.927%.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/16: Not to exceed the maximum ICF/ID rate per day plus 3.927%.

Provider category	Basis of reimbursement	Upper limit
26. Day habilitation	Fee schedule	Effective 7/1/16: Provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute or daily rate. If no 6/30/16 rate: $3.51 per 15-minute unit or $68.23 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 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $9.28 per 15-minute unit.
29. In-home family therapy	Fee schedule	Effective 7/1/16, provider's rate in effect 6/30/16 plus 1%, converted to a 15-minute rate. If no 6/30/16 rate: $24.85 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 7/1/16, provider's rate in effect 6/30/16 plus 1%. If no 6/30/16 rate: $16.07 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.
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.

Provider category	Basis of reimbursement	Upper limit
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	$26.08 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 Career exploration	Fee schedule	Fee schedule in effect May 4, 2016.
5. Supported employment:		
Individual supported employment	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed $3,029.00 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect May 4, 2016. Total monthly cost for all supported employment services not to exceed $3,029.00 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect May 4, 2016. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,029.00 per month.

Provider category	Basis of reimbursement	Upper limit
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 7/1/16: Medicare LUPA rates in effect on 6/30/16 plus a 2.93% increase.
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 facilities	1. Daily visit rate approved by the U.S. Indian Health Service (IHS) for services provided to American Indian and Alaskan native members. See 79.1(1)*"h"*	1. IHS-approved rate published in the Federal Register as outpatient per visit rate (excluding Medicare).
	2. Fee schedule for service provided for all other Medicaid members.	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%.
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%.

Provider category	Basis of reimbursement	Upper limit
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.

Provider category	Basis of reimbursement	Upper limit
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. See 79.1(7)*"d"*	Fee schedule in effect 7/1/17. See 79.1(7)*"d."*
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"*

Provider category	Basis of reimbursement	Upper limit
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	Fee schedule	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%.
Psychiatric services	Fee schedule	Fee schedule in effect 1/1/16.
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—Chapter 73	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 $75,000. 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 30 days for same condition. Effective for dates of service on or after July 1, 2015, when an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within 30 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. The fee schedule amount paid to physicians based on paragraph 79.1(7)*"a"* shall be reduced by an adjustment factor, as determined by the department and published with the Iowa Medicaid fee schedule, to reflect the lower cost of providing physician services in a facility setting, as opposed to the physician's office. For the purpose of this provision, a "facility" place of service (POS) is defined as any of the following (consistent with "POS" definitions under Medicare, per the Medicare Claims Processing Manual, Chapter 12, Section 20.4.2, revised as of May 2017):

(1) Telehealth (POS 02).

(2) Outpatient hospital-off campus (POS 19).

(3) Inpatient hospital (POS 21).

(4) Outpatient hospital-on campus (POS 22).

(5) Emergency room-hospital (POS 23).

(6) Ambulatory surgical center (POS 24).
(7) Military treatment center (POS 26).
(8) Skilled nursing facility (POS 31).
(9) Hospice-for inpatient care (POS 34).
(10) Ambulance-land (POS 41).
(11) Ambulance-air or water (POS 42).
(12) Inpatient psychiatric facility (POS 51).
(13) Psychiatric facility-partial hospitalization (POS 52).
(14) Community mental health center (POS 53).
(15) Psychiatric residential treatment center (POS 56).
(16) Comprehensive inpatient rehabilitation (POS 61).

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 January 1, 2015, through June 30, 2017, 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).

d. Payment for anesthesia services. Anesthesia services are paid pursuant to this paragraph and the Iowa Medicaid fee schedule published by the department pursuant to paragraph 79.1(1)*"c."* Anesthesia procedures listed in the fee schedule with a factor code of "F" are paid at the dollar amount of the factor listed for the procedure in the fee schedule. Anesthesia procedures listed in the fee schedule with a factor code of "A" are paid a dollar amount equal to the Iowa Medicaid anesthesia conversion factor multiplied by the sum of the minutes of service provided and the factor listed for the procedure in the fee schedule. Beginning July 1, 2017, the Iowa Medicaid anesthesia conversion factor is the current Medicare anesthesia conversion factor for Iowa, converted to a per-minute amount. For 2017, that amount is $1.40, which will be updated annually on January 1.

79.1(8) *Drugs.*

a. Except as provided below in paragraphs 79.1(8)*"d"* through *"i,"* all providers are reimbursed for covered drugs as follows:

(1) 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 state actual acquisition cost (AAC), determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"c."*

2. The federal upper limit (FUL), defined as the upper limit for a multiple source drug established in accordance with the methodology of the Centers for Medicare and Medicaid Services as described in 42 CFR 447.514(a)-(c), plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"c."*

3. The total submitted charge.

4. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

1. The average state AAC, determined pursuant to paragraph 79.1(8)*"b,"* plus the professional dispensing fee determined pursuant to paragraph 79.1(8)*"c."*

2. The total submitted charge.

3. Providers' usual and customary charge to the general public.

b. For purposes of this subrule, average state AAC is defined as retail pharmacies' average prices paid to acquire drug products. Average state 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 state AAC shall be calculated as a statistical mean based on one reported cost per drug per pharmacy. The average state AAC determined by the department shall be published on the Iowa Medicaid enterprise Web site. If no current average state AAC has been determined for a drug, the wholesale acquisition cost (WAC) published by Medi-Span shall be used as the average state AAC.

c. For purposes of this subrule, 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. The survey shall be conducted every two years beginning in state fiscal year 2014-2015.

d. For an oral solid dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist, an additional one cent per dose shall be added to reimbursement based on acquisition cost or FUL.

e. 340B-purchased drugs.

(1) Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement to a covered entity as defined in 42 U.S.C. 256b(a)(4) for covered outpatient drugs acquired by the entity through the 340B drug pricing program will be the lowest of:

1. The submitted 340B covered entity actual acquisition cost (not to exceed the 340B ceiling price) plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

2. The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

3. For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

4. The total submitted charge; or

5. Providers' usual and customary charge to the general public.

(2) Reimbursement for covered outpatient drugs to a 340B contract pharmacy, under contract with a covered entity described in 42 U.S.C. 256b(a)(4), will be according to paragraph 79.1(8)*"a"* because covered outpatient drugs purchased through the 340B drug pricing program cannot be billed to Medicaid by a 340B contract pharmacy.

f. Federal supply schedule (FSS) drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by a provider through the FSS program managed by the federal General Services Administration will be the lowest of:

(1) The provider's actual acquisition cost, not to exceed the FSS price, plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c";*

(4) The total submitted charge; or

(5) Providers' usual and customary charge to the general public.

g. Nominal-price drugs. Notwithstanding paragraph 79.1(8)*"a"* above, reimbursement for drugs acquired by providers at nominal prices and excluded from the calculation of the drug's "best price" pursuant to 42 CFR 447.508 will be the lowest of:

(1) The provider's actual acquisition cost (not to exceed the nominal price paid) plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(2) The average state AAC determined pursuant to paragraph 79.1(8)*"b"* plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(3) For generic prescription drugs and nonprescription drugs only, the FUL pursuant to 79.1(8)*"a"*(1)"2" plus the professional dispensing fee pursuant to paragraph 79.1(8)*"c"*;

(4) The total submitted charge; or

(5) Providers' usual and customary charge to the general public.

h. Indian health facilities enrolled pursuant to rule 441—77.45(249A). For all drugs provided to American Indians or Alaskan natives by Indian health facilities enrolled pursuant to rule 441—77.45(249A), reimbursement is one pharmacy encounter payment per date of service, notwithstanding paragraphs 79.1(8)*"a"* through *"f."* The pharmacy encounter rate is the current "outpatient per visit rate (excluding Medicare)" approved by the U.S. Indian Health Service (IHS) for services provided by IHS facilities to Medicaid beneficiaries, as published in the Federal Register, and includes reimbursement for the dispensing fees, ingredient cost, and any necessary counseling by the pharmacist.

i. Vaccines for Children Program. All providers administering vaccines 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. Providers may receive Medicaid reimbursement for the administration of vaccines to Medicaid members through the otherwise applicable reimbursement for inpatient or outpatient services.

j. Physician-administered drugs. Notwithstanding paragraphs 79.1(8)*"a"* through *"f,"* 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 the physician payment policy under subrule 79.1(2).

k. Under this subrule, no payment shall be made for sales tax.

l. For purposes of this subrule, the Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic.

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; 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) For services provided from July 1, 2015, through June 30, 2016, 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) For services provided from July 1, 2015, through June 30, 2016, 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.

(4) For services provided on or after July 1, 2016, revenues exceeding adjusted actual costs by more than 5.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(5) For services provided on or after July 1, 2016, providers who do not reimburse revenues exceeding 105.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 105.5 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.

"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 OPPS 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 (OPPS) 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.

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 OPPS 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 OPPS 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 OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● 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.	For services covered by Iowa Medicaid as an outpatient hospital service, the 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."* For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. ● 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	If covered by Iowa Medicaid as an outpatient hospital service, the 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 as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: ● 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.	If covered by Iowa Medicaid, the item, code, 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, code, or service is not paid under OPPS APC or any other Medicaid payment system.

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: ● 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	Paid under OPPS APC. ● 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	Paid under OPPS APC. ● 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	If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.
R	Blood and blood products	If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
U	Brachytherapy sources	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

Indicator	Item, Code, or Service	OPPS Payment Status
V	Clinic or emergency department visit	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."* If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
Y	Nonimplantable durable medical equipment	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."* 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).

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.

1. For members who were referred to the emergency room by appropriate medical personnel, 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 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.

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.

Service	Payment amount	Number of payments
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 version of the Code on Dental Procedures and Nomenclature (CDT) published by the American Dental Association.

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.* Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for Medicare crossover claims shall be made as follows.

a. *Definitions.* For purposes of this subrule:

"Medicare crossover claim" means a claim for Medicaid payment for services covered by Medicare Part A or Part B rendered to a Medicare beneficiary who is also eligible for Medicaid. Medicare crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

"Medicaid-allowed amount" means the Medicaid reimbursement for the service(s) rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

"Medicare-allowed amount" means the total reimbursement allowed by Medicare for the service(s) rendered, for a participating Medicare provider who has accepted Medicare assignment of claims for services rendered, including any portion to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare deductible and coinsurance amounts" means the portion of the Medicare-allowed amount to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Medicare provider reimbursement" means the Medicare-allowed amount less any portion thereof to be paid by the Medicare beneficiary as a deductible or coinsurance.

"Third-party payment" means payment from any source other than Medicaid, Medicare, or the Medicaid and Medicare beneficiary.

b. *Reimbursement of Medicare crossover claims.* Covered Medicare crossover claims shall be paid by Medicaid at the lesser of:

(1) Applicable Medicare deductible and coinsurance amounts, less any third-party payment available to the provider for the Medicare deductible and coinsurance amounts and any Medicaid copayment or spenddown; or

(2) Either:

1. For Medicaid-covered services: the Medicaid-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown; or

2. For non-Medicaid-covered services: 50 percent of the Medicare-allowed amount less the Medicare provider reimbursement, any third-party payment available to the provider in addition to the Medicare provider reimbursement, and any Medicaid copayment or spenddown.

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

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

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 approved by the department of human services. Once a community mental health center chooses the alternative reimbursement rate methodology, 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 extensionxls orxlsx. 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.

79.1(28) *Reimbursement for community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services.*

a. New providers. Providers who are newly enrolled shall be paid prospective rates based on projected reasonable and proper costs of operation based on the statewide average rate paid to community-based neurobehavioral rehabilitation service providers in effect June 30 each fiscal year.

b. Established providers. After establishment of the initial rate for a provider, the rate will be adjusted annually, effective July 1 each year. The provider's new rate shall be the previously established rate adjusted by the consumer price index for all urban consumers for the preceding 12-month period ending June 30, not to exceed the limit in effect June 30.

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 9996B**, 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; **ARC 2075C**, IAB 8/5/15, effective 7/15/15; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2167C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2846C**, IAB 12/7/16, effective 11/15/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2930C**, IAB 2/1/17, effective 4/1/17; **ARC 2932C**, IAB 2/1/17, effective 3/8/17; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3158C**, IAB 7/5/17, effective 7/1/17; **ARC 3161C**, IAB 7/5/17, effective 7/1/17; **ARC 3162C**, IAB 7/5/17, effective 7/1/17; **ARC 3160C**, IAB 7/5/17, effective 7/1/17; **ARC 3159C**, IAB 7/5/17, effective 7/1/17]

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.

(42) Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services:

1. Department-approved standardized neurobehavioral assessment tool.
2. Community-based neurobehavioral treatment order.
3. Treatment plan.
4. Clinical records documenting diagnosis and treatment history.
5. Progress or status notes.
6. Service notes or narratives.
7. Procedure, laboratory, or test orders and results.
8. Therapy notes including but not limited to occupational therapy, physical therapy, and speech-language pathology services as applicable.
9. Medication administration records.

(43) Child care medical services:

1. Plan of care.
2. Certification and recertification.
3. Service notes or narratives.
4. Physician orders or medical orders.
5. Abbreviation list (a copy of the abbreviation list utilized within the member's record).
6. If initials or incomplete signatures are noted within the member's record, a signature log (a typed listing of each provider's name, including initials, professional credentials and title, followed by the individual provider's signature).

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; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2341C**, IAB 1/6/16, effective 2/10/16]

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.*

a. Definitions.

"Co-chairpersons" means the public health director co-chairperson and the public co-chairperson.

"Public co-chairperson" means the individual selected by the other publicly appointed members of the council to serve as a co-chairperson of the council.

"Public health director co-chairperson" means the director of the department of public health, who serves as a co-chairperson of the council.

b. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

c. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

d. The position of public co-chairperson shall be held by one of the ten publicly appointed council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff.

e. The co-chairpersons shall appoint members to other committees approved by the council.

f. The co-chairpersons shall also serve on the executive committee and will serve as the co-chairpersons of that committee.

g. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the full council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the executive committee to receive the council's feedback and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council and executive committee meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership.* The membership of the council and its executive committee shall be as prescribed at Iowa Code sections 249A.4B(2), 249A.4B(3), and 249A.4B(4a).

a. Council membership.

(1) Council membership of professional and business entities shall consist of those entities outlined in Iowa Code section 249A.4B(2). Professional and business entities shall identify their representatives and report information to the department of human services.

1. If an entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternate contact is needed.

2. Professional and business entities shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years, regardless of the representative's meeting attendance.

3. All professional and business entities will be voting members of the council.

(2) Council membership of public representatives shall consist of ten representatives which may include members of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, appointed by the governor for staggered terms of two years each, none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented in Iowa Code sections 249A.4B(2) and 249A.4B(3) and a majority of whom shall be current or former recipients of medical assistance or members of the families of current or former recipients. All public representatives will be voting members of the council.

(3) A member of the HAWK-I board, created in Iowa Code section 514I.5, selected by the members of the HAWK-I board, shall be a member of the council. The HAWK-I board member representative will be a voting member of the council.

(4) Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

1. Partner agency and medical school representatives will be nonvoting members of the council.

2. If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

3. Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years, regardless of the representative's meeting attendance.

(5) The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

1. Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

2. Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

b. Executive committee membership. Executive committee membership shall consist of the following:

(1) Five professional and business entities identified in Iowa Code section 249A.4B(2). The entity, not the individual representative, is selected for membership on the executive committee. Each selected entity shall appoint its individual representative. Professional and business entities of the council vote to select the business and professional entities of the executive committee.

(2) Five individuals appointed to the council as public members, pursuant to Iowa Code section 249A.4B(2).

1. One of the five public member positions on the executive committee will be held by the co-chairperson identified in subrule 79.7(1).

2. At least one public member shall be a recipient of medical assistance.

3. Public members of the council vote to select the public members of the executive committee.

(3) The co-chairpersons identified in subrule 79.7(1), who shall serve as the co-chairpersons of the executive committee.

(4) The executive committee will be elected for two-year terms, beginning at the start of a state fiscal year.

1. All voting members of the council will be eligible for election to the executive committee, based on the criteria outlined in this paragraph.

2. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff.

3. Should any vacancy occur on the executive committee, a special election will be held following the standards outlined in this paragraph.

4. Ballots should include the professional and business entity name but omit the name of the representative of the entity.

79.7(3) *Responsibilities, duties and meetings.* The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services through the executive committee of the council.

a. Recommendations. Recommendations made by the executive committee from the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The executive committee will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

(6) The council shall review the recommendations submitted by the executive committee regarding feedback received at the IA Health Link statewide public comment meetings outlined in 2016 Iowa Acts, chapter 1139, section 102.

c. Executive committee.

(1) Executive committee meetings.

1. The executive committee shall meet on a monthly basis.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of executive committee members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. In a month when a council meeting is held, the executive committee shall meet after the council meeting, allowing committee members to discuss and make recommendations based on the topics discussed by council members.

(2) Based on the deliberations of the full council, the executive committee shall make recommendations to the director of human services 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 program recipients.

5. Advice on such administrative and fiscal matters as the director of human services may request.

(3) Pursuant to 2016 Iowa Acts, chapter 1139, section 102, the executive committee shall review the compilation of the input and recommendations from the public meetings convened statewide and shall submit recommendations based upon the compilation to the director of human services on a quarterly basis through December 31, 2017.

79.7(4) *Procedures.*

a. Procedures shall apply to both the council and the executive committee.

b. A quorum shall consist of 50 percent of the current voting members.

c. Where a quorum is present, a position is carried by two-thirds of the council members present.

d. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the full council.

e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *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.

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council and executive committee.

e. The department shall be responsible for the organization of all council and executive committee meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council and of the executive committee will be kept by the department. The co-chairpersons will review minutes before distribution.

g. The department shall compile input and recommendations received at the public meetings established in 2016 Iowa Acts, chapter 1139, section 102, and submit the information to the executive committee for review.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09; **ARC 3006C**, IAB 3/29/17, effective 6/1/17]

441—79.8(249A) Requests for prior authorization. This rule governs requests for prior authorization for services not provided through a managed care organization. For services provided through a managed care organization, the prior authorization request is submitted, reviewed, and authorized by the managed care organization.

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 must be submitted on any Request for Prior Authorization form designated for the drug being requested in the preferred drug list published pursuant to Iowa Code chapter 249A.

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.

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

(1) The conditions for payment outlined in the provider manual with reference to coverage and duration.

(2) The determination made by the Medicare program unless specifically stated differently in state law or rule.

(3) The recommendation to the department from the appropriate advisory committee.

(4) Whether there are other less expensive procedures which are covered and which would be as effective.

(5) The advice of an appropriate professional consultant.

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

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.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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 73.

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

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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 73.

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

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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, including those enrolled with a managed care organization, shall begin the enrollment process by completing the appropriate application on the Iowa Medicaid enterprise Web site. Managed care organizations and fiscal agents are exempt from completing an application.

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; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

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.

[**ARC 9254B**, IAB 12/1/10, effective 1/1/11; **ARC 9531B**, IAB 6/1/11, effective 5/12/11; **ARC 0824C**, IAB 7/10/13, effective 9/1/13]

441—79.17(249A) 2013 reimbursement rate increases. Rescinded **ARC 1056C**, IAB 10/2/13, effective 11/6/13.

[Filed March 11, 1970]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 3/25/77, Notice 12/1/76—published 4/20/77, effective 5/25/77]
[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]
[Filed 10/24/77, Notice 9/7/77—published 11/16/77, effective 12/21/77]
[Filed 12/6/77, Notice 10/19/77—published 12/28/77, effective 2/1/78]
[Filed 1/16/78, Notice 11/30/77—published 2/8/78, effective 4/1/78]
[Filed 8/9/78, Notice 6/28/78—published 9/6/78, effective 10/11/78]
[Filed 10/10/78, Notice 7/26/78—published 11/1/78, effective 12/6/78]
[Filed 3/30/79, Notice 2/21/79—published 4/18/79, effective 5/23/79]
[Filed 9/6/79, Notice 7/11/79—published 10/3/79, effective 11/7/79]
[Filed 12/5/79, Notice 10/3/79—published 12/26/79, effective 1/30/80]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed 11/21/80, Notice 9/3/80—published 12/10/80, effective 1/14/81]
[Filed 3/24/81, Notice 2/4/81—published 4/15/81, effective 6/1/81]
[Filed emergency 4/23/81—published 5/13/81, effective 4/23/81]
[Filed 8/24/81, Notice 3/4/81—published 9/16/81, effective 11/1/81]
[Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]
[Filed emergency 3/26/82—published 4/14/82, effective 4/1/82]
[Filed emergency 5/21/82—published 6/9/82, effective 7/1/82]
[Filed 7/30/82, Notice 6/9/82—published 8/18/82, effective 10/1/82]
[Filed emergency 8/20/82 after Notice of 6/23/82—published 9/15/82, effective 10/1/82]
[Filed 11/19/82, Notice 9/29/82—published 12/8/82, effective 2/1/83]
[Filed 2/25/83, Notice 1/5/83—published 3/16/83, effective 5/1/83]
[Filed 5/20/83, Notice 3/30/83—published 6/8/83, effective 8/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]

[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed emergency 10/28/83—published 11/23/83, effective 12/1/83]
[Filed emergency 11/18/83—published 12/7/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed 1/13/84, Notice 11/23/84—published 2/1/84, effective 3/7/84]
[Filed 2/10/84, Notice 12/7/83—published 2/29/84, effective 5/1/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency after Notice 11/1/84, Notice 7/18/84—published 11/21/84, effective 11/1/84]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed emergency 12/2/85—published 12/18/85, effective 1/1/86]
[Filed 12/2/85, Notice 10/9/85—published 12/18/85, effective 2/1/86]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed 2/21/86, Notices 12/18/85, 1/15/86—published 3/12/86, effective 5/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]
[Filed 10/17/86, Notice 8/27/86—published 11/5/86, effective 1/1/87]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed 4/29/87, Notice 3/11/87—published 5/20/87, effective 7/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 7/24/87, Notice 5/20/87—published 8/12/87, effective 10/1/87]
[Filed emergency 8/28/87—published 9/23/87, effective 9/1/87]
[Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
[Filed 10/23/87, Notice 8/26/87—published 11/18/87, effective 1/1/88]
[Filed without Notice 11/25/87—published 12/16/87, effective 2/1/88]
[Filed 11/30/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
[Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88][1]
[Filed 1/21/88, Notice 12/16/87—published 2/10/88, effective 4/1/88]
[Filed emergency 4/28/88 after Notice 3/23/88—published 5/18/88, effective 6/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88][2 4]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
[Filed emergency 10/28/88—published 11/16/88, effective 11/1/88]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 12/1/88, 1/1/89]
[Filed emergency 12/22/88 after Notice of 11/16/88—published 1/11/89, effective 1/1/89]
[Filed 12/22/88, Notices 11/16/88[2 4]—published 1/11/89, effective 3/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed emergency 1/10/90 after Notice of 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 1/17/90, Notice 8/23/90—published 2/7/90, effective 4/1/90][3]
[Filed emergency 2/14/90—published 3/7/90, effective 4/1/90]
[Filed 4/13/90, Notices 2/21/90, 3/7/90—published 5/2/90, effective 7/1/90]
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
[Filed emergency 5/11/90—published 5/30/90, effective 6/1/90]
[Filed 5/11/90, Notice 4/4/90—published 5/30/90, effective 8/1/90]

[Filed emergency 6/14/90 after Notice 5/2/90—published 7/11/90, effective 7/1/90]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
[Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
[Filed 8/16/90, Notices 7/11/90[2 4]—published 9/5/90, effective 11/1/90]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed emergency 1/17/91 after Notice 11/28/90—published 2/6/91, effective 2/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
[Filed emergency 2/22/91—published 3/20/91, effective 3/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
[Filed emergency 6/14/91—published 7/10/91, effective 7/1/91]
[Filed 6/14/91, Notices 3/20/91, 5/1/91—published 7/10/91, effective 9/1/91][5]
[Filed 7/10/91, Notice 5/29/91—published 8/7/91, effective 10/1/91]
[Filed emergency 9/18/91 after Notice 7/24/91—published 10/16/91, effective 10/1/91]
[Filed 9/18/91, Notices 7/10/91, 7/24/91—published 10/16/91, effective 12/1/91]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92]
[Filed 12/11/91, Notice 10/30/91—published 1/8/92, effective 3/1/92]
[Filed emergency 1/16/92 after Notice 11/27/91—published 2/5/92, effective 3/1/92][6]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 4/8/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 5/13/92 after Notice 4/1/92—published 6/10/92, effective 5/14/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 6/11/92, Notices 3/18/92, 4/29/92—published 7/8/92, effective 9/1/92]
[Filed without Notice 6/11/92—published 7/8/92, effective 9/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed emergency 9/11/92—published 9/30/92, effective 10/1/92]
[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
[Filed 10/15/92, Notice 8/19/92—published 11/11/92, effective 1/1/93]
[Filed 11/10/92, Notice 9/30/92—published 12/9/92, effective 2/1/93]
[Filed emergency 12/30/92 after Notice 11/25/92—published 1/20/93, effective 1/1/93]
[Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
[Filed 3/11/93, Notice 1/20/93—published 3/31/93, effective 6/1/93]
[Filed 4/15/93, Notice 3/3/93—published 5/12/93, effective 7/1/93]
[Filed emergency 5/14/93 after Notice 3/31/93—published 6/9/93, effective 6/1/93]
[Filed 5/14/93, Notice 3/31/93—published 6/9/93, effective 8/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed 6/11/93, Notice 4/28/93—published 7/7/93, effective 9/1/93]
[Filed emergency 6/25/93—published 7/21/93, effective 7/1/93]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notices 4/28/93, 7/7/93—published 9/1/93, effective 11/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 12/1/93]
[Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
[Filed 11/12/93, Notice 9/29/93—published 12/8/93, effective 2/1/94]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed 1/12/94, Notice 11/10/93—published 2/2/94, effective 4/1/94]
[Filed 3/10/94, Notices 1/19/94, 2/2/94—published 3/30/94, effective 6/1/94][2 4]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 9/15/94, Notice 7/6/94—published 10/12/94, effective 12/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notices 10/12/94, 11/9/94—published 1/4/95, effective 3/1/95]

[Filed 3/20/95, Notice 2/1/95—published 4/12/95, effective 6/1/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed 11/16/95, Notices 8/2/95, 9/27/95—published 12/6/95, effective 2/1/96][24]
[Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed 7/10/96, Notice 6/5/96—published 7/31/96, effective 10/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 9/17/96, Notice 7/31/96—published 10/9/96, effective 12/1/96]
[Filed 11/13/96, Notice 9/11/96—published 12/4/96, effective 2/1/97]
[Filed 2/12/97, Notice 12/18/96—published 3/12/97, effective 5/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 9/16/97, Notice 7/2/97—published 10/8/97, effective 12/1/97]
[Filed emergency 11/12/97—published 12/3/97, effective 11/12/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 1/14/98, Notices 11/19/97, 12/3/97—published 2/11/98, effective 4/1/98]
[Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 9/15/98, Notice 7/15/98—published 10/7/98, effective 12/1/98]
[Filed 11/10/98, Notice 9/23/98—published 12/2/98, effective 2/1/99]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 6/10/99, Notice 5/5/99—published 6/30/99, effective 9/1/99]
[Filed 7/15/99, Notice 5/19/99—published 8/11/99, effective 10/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 11/10/99, Notice 9/22/99—published 12/1/99, effective 2/1/00]
[Filed 4/12/00, Notice 2/9/00—published 5/3/00, effective 7/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed emergency 9/12/00 after Notice 7/26/00—published 10/4/00, effective 10/1/00]
[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed 10/11/00, Notice 8/23/00—published 11/1/00, effective 1/1/01]
[Filed 11/8/00, Notice 9/20/00—published 11/29/00, effective 2/1/01]
[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
[Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed 5/9/01, Notice 4/4/01—published 5/30/01, effective 8/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01][24]
[Filed 6/13/01, Notice 4/18/01—published 7/11/01, effective 9/1/01]
[Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]

[Filed 10/10/01, Notice 8/22/01—published 10/31/01, effective 1/1/02][2 4]
[Filed 11/14/01, Notice 10/3/01—published 12/12/01, effective 2/1/02]
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
[Filed emergency 1/16/02—published 2/6/02, effective 2/1/02][7]
[Filed 3/13/02, Notice 1/23/02—published 4/3/02, effective 6/1/02]
[Filed emergency 4/12/02—published 5/1/02, effective 4/12/02]
[Filed 4/10/02, Notice 1/9/02—published 5/1/02, effective 7/1/02]
[Filed 4/10/02, Notice 2/6/02—published 5/1/02, effective 7/1/02]
[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02][8]
[Filed 7/15/02, Notice 5/29/02—published 8/7/02, effective 10/1/02]
[Filed 8/15/02, Notice 6/12/02—published 9/4/02, effective 11/1/02]
[Filed 8/15/02, Notice 6/26/02—published 9/4/02, effective 11/1/02]
[Filed emergency 9/12/02—published 10/2/02, effective 9/12/02]
[Filed emergency 11/18/02—published 12/11/02, effective 12/1/02]
[Filed 11/18/02, Notice 10/2/02—published 12/11/02, effective 2/1/03]
[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
[Filed 2/13/03, Notice 12/11/02—published 3/5/03, effective 5/1/03]
[Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03][2 4]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03][2 4]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03][2 4]
[Filed 10/10/03, Notice 8/20/03—published 10/29/03, effective 1/1/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed emergency 6/14/04—published 7/7/04, effective 7/1/04][2 4]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
[Filed 9/23/04, Notice 7/7/04—published 10/13/04, effective 11/17/04][2 4]
[Filed emergency 4/15/05—published 5/11/05, effective 5/1/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 6/17/05—published 7/6/05, effective 6/25/05]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05][2 4]
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed emergency 10/21/05 after Notice 7/6/05—published 11/9/05, effective 10/21/05]
[Filed 10/21/05, Notices 5/11/05 and 7/6/05?—published 11/9/05, effective 12/14/05]
[Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
[Filed 4/17/06, Notice 2/15/06—published 5/10/06, effective 7/1/06]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 6/16/06, Notice 4/26/06—published 7/5/06, effective 9/1/06]
[Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
[Filed 8/10/06, Notice 2/15/06—published 8/30/06, effective 11/1/06]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 10/12/06 after Notice 8/30/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06—published 1/3/07, effective 1/1/07]
[Filed 2/15/07, Notice 12/20/06—published 3/14/07, effective 5/1/07]
[Filed emergency 3/14/07 after Notice 1/3/07—published 4/11/07, effective 4/1/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
[Filed emergency 8/9/07 after Notice 7/4/07—published 8/29/07, effective 8/10/07]
[Filed 8/9/07, Notice 7/4/07—published 8/29/07, effective 10/3/07]
[Filed 8/9/07, Notice 6/20/07—published 8/29/07, effective 11/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]

[Filed emergency 10/10/07—published 11/7/07, effective 10/10/07]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 3/5/08]
[Filed 1/9/08, Notice 11/7/07—published 1/30/08, effective 4/1/08]
[Filed emergency 5/14/08 after Notice 3/26/08—published 6/4/08, effective 6/1/08]
[Filed emergency 6/11/08 after Notice 3/12/08—published 7/2/08, effective 7/1/08]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
[Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
[Filed emergency 10/14/08 after Notice 7/16/08—published 11/5/08, effective 12/1/08]
[Filed 12/11/08, Notice 10/22/08—published 1/14/09, effective 3/1/09]
[Filed ARC 7835B (Notice ARC 7627B, IAB 3/11/09), IAB 6/3/09, effective 7/8/09]
[Filed Emergency ARC 7937B, IAB 7/1/09, effective 7/1/09]
[Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09][10]
[Filed ARC 8205B (Notice ARC 7827B, IAB 6/3/09), IAB 10/7/09, effective 11/11/09]
[Filed ARC 8206B (Notice ARC 7938B, IAB 7/1/09), IAB 10/7/09, effective 11/11/09]
[Filed ARC 8262B (Notice ARC 8084B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
[Filed ARC 8263B (Notice ARC 8059B, IAB 8/26/09), IAB 11/4/09, effective 12/9/09]
[Filed Emergency ARC 8344B, IAB 12/2/09, effective 12/1/09]
[Filed Emergency ARC 8647B, IAB 4/7/10, effective 3/11/10]
[Filed Emergency ARC 8649B, IAB 4/7/10, effective 3/11/10]
[Filed Emergency After Notice ARC 8643B (Notice ARC 8345B, IAB 12/2/09), IAB 4/7/10, effective 3/11/10]
[Filed Emergency ARC 8894B, IAB 6/30/10, effective 7/1/10]
[Filed Emergency ARC 8899B, IAB 6/30/10, effective 7/1/10]
[Filed Emergency ARC 9046B, IAB 9/8/10, effective 8/12/10]
[Filed ARC 9127B (Notice ARC 8896B, IAB 6/30/10), IAB 10/6/10, effective 11/10/10]
[Filed Emergency ARC 9134B, IAB 10/6/10, effective 10/1/10]
[Filed Emergency ARC 9132B, IAB 10/6/10, effective 11/1/10]
[Filed ARC 9176B (Notice ARC 8900B, IAB 6/30/10), IAB 11/3/10, effective 12/8/10]
[Filed Emergency ARC 9254B, IAB 12/1/10, effective 1/1/11]
[Filed ARC 9316B (Notice ARC 9133B, IAB 10/6/10), IAB 12/29/10, effective 2/2/11]
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]
[Filed Emergency After Notice ARC 9440B (Notice ARC 9276B, IAB 12/15/10), IAB 4/6/11, effective 4/1/11]
[Filed ARC 9487B (Notice ARC 9399B, IAB 2/23/11), IAB 5/4/11, effective 7/1/11]
[Filed Emergency After Notice ARC 9531B (Notice ARC 9431B, IAB 3/23/11), IAB 6/1/11, effective 5/12/11]
[Filed ARC 9588B (Notice ARC 9367B, IAB 2/9/11; Amended Notice ARC 9448B, IAB 4/6/11), IAB 6/29/11, effective 9/1/11]
[Filed Emergency ARC 9706B, IAB 9/7/11, effective 8/17/11]
[Filed Emergency ARC 9708B, IAB 9/7/11, effective 8/17/11]
[Filed Emergency ARC 9710B, IAB 9/7/11, effective 8/17/11]
[Filed Emergency ARC 9704B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9712B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9714B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9719B, IAB 9/7/11, effective 9/1/11]
[Filed Emergency ARC 9722B, IAB 9/7/11, effective 9/1/11]
[Filed ARC 9884B (Notice ARC 9705B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9886B (Notice ARC 9713B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9887B (Notice ARC 9715B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed ARC 9958B (Notice ARC 9707B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]
[Filed ARC 9959B (Notice ARC 9721B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]

[Filed ARC 9960B (Notice ARC 9723B, IAB 9/7/11), IAB 1/11/12, effective 2/15/12]
[Filed Emergency ARC 9996B, IAB 2/8/12, effective 1/19/12]
[Filed ARC 0028C (Notice ARC 9711B, IAB 9/7/11), IAB 3/7/12, effective 4/11/12]
[Filed ARC 0029C (Notice ARC 9709B, IAB 9/7/11), IAB 3/7/12, effective 4/11/12]
[Nullified amendment editorially removed, IAC Supplement 5/16/12][11]
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency ARC 0194C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency ARC 0196C, IAB 7/11/12, effective 7/1/12]
[Filed Emergency After Notice ARC 0198C (Notice ARC 0117C, IAB 5/2/12), IAB 7/11/12, effective 7/1/12]
[Filed ARC 0358C (Notice ARC 0231C, IAB 7/25/12), IAB 10/3/12, effective 11/7/12]
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0354C (Notice ARC 0195C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0355C (Notice ARC 0197C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0360C (Notice ARC 0203C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0485C (Notice ARC 0259C, IAB 8/8/12), IAB 12/12/12, effective 2/1/13]
[Filed ARC 0545C (Notice ARC 0366C, IAB 10/3/12), IAB 1/9/13, effective 3/1/13]
[Filed Emergency ARC 0548C, IAB 1/9/13, effective 1/1/13]
[Filed ARC 0580C (Notice ARC 0434C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed ARC 0581C (Notice ARC 0436C, IAB 10/31/12), IAB 2/6/13, effective 4/1/13]
[Filed Emergency ARC 0585C, IAB 2/6/13, effective 1/9/13]
[Filed ARC 0665C (Notice ARC 0547C, IAB 1/9/13), IAB 4/3/13, effective 6/1/13]
[Filed ARC 0708C (Notice ARC 0568C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0711C (Notice ARC 0570C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0712C (Notice ARC 0569C, IAB 1/23/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0710C (Notice ARC 0588C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0713C (Notice ARC 0584C, IAB 2/6/13), IAB 5/1/13, effective 7/1/13]
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
[Filed ARC 0823C (Notice ARC 0649C, IAB 3/20/13), IAB 7/10/13, effective 9/1/13]
[Filed ARC 0824C (Notice ARC 0669C, IAB 4/3/13), IAB 7/10/13, effective 9/1/13]
[Filed Emergency After Notice ARC 0838C (Notice ARC 0667C, IAB 4/3/13; Amended Notice ARC 0748C, IAB 5/15/13), IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0840C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0848C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0864C, IAB 7/24/13, effective 7/1/13]
[Filed ARC 0994C (Notice ARC 0789C, IAB 6/12/13), IAB 9/4/13, effective 11/1/13]
[Filed Emergency After Notice ARC 1071C (Notice ARC 0887C, IAB 7/24/13), IAB 10/2/13, effective 10/1/13]
[Filed ARC 1058C (Notice ARC 0863C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1057C (Notice ARC 0839C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1051C (Notice ARC 0847C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1150C (Notice ARC 0918C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1152C (Notice ARC 0910C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1154C (Notice ARC 0919C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1155C (Notice ARC 0912C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1153C (Notice ARC 0917C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 1481C (Notice ARC 1391C, IAB 4/2/14), IAB 6/11/14, effective 8/1/14]
[Filed Emergency ARC 1519C, IAB 7/9/14, effective 7/1/14]
[Filed Emergency ARC 1521C, IAB 7/9/14, effective 7/1/14]

[Filed Emergency After Notice ARC 1610C (Notice ARC 1510C, IAB 6/25/14), IAB 9/3/14, effective 8/13/14]
[Filed ARC 1609C (Notice ARC 1518C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
[Filed ARC 1608C (Notice ARC 1520C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
[Filed ARC 1695C (Notice ARC 1621C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
[Filed ARC 1697C (Notice ARC 1619C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
[Filed ARC 1699C (Notice ARC 1617C, IAB 9/3/14), IAB 10/29/14, effective 1/1/15]
[Filed ARC 1977C (Notice ARC 1818C, IAB 1/7/15), IAB 4/29/15, effective 7/1/15]
[Filed ARC 2026C (Notice ARC 1921C, IAB 3/18/15), IAB 6/10/15, effective 8/1/15]
[Filed Emergency ARC 2075C, IAB 8/5/15, effective 7/15/15]
[Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
[Filed ARC 2167C (Notice ARC 2076C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 2341C (Notice ARC 2113C, IAB 8/19/15), IAB 1/6/16, effective 2/10/16]
[Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
[Filed Emergency ARC 2846C, IAB 12/7/16, effective 11/15/16]
[Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
[Filed ARC 2930C (Notice ARC 2824C, IAB 11/23/16), IAB 2/1/17, effective 4/1/17]
[Filed ARC 2932C (Notice ARC 2847C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
[Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
[Filed ARC 3006C (Notice ARC 2899C, IAB 1/18/17), IAB 3/29/17, effective 6/1/17]
[Filed Emergency ARC 3158C, IAB 7/5/17, effective 7/1/17]
[Filed Emergency ARC 3161C, IAB 7/5/17, effective 7/1/17]
[Filed Emergency ARC 3162C, IAB 7/5/17, effective 7/1/17]
[Filed Emergency ARC 3160C, IAB 7/5/17, effective 7/1/17]
[Filed Emergency ARC 3159C, IAB 7/5/17, effective 7/1/17]

[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] Two ARCs

[3] 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.

[4] Two or more ARCs

[5] 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.

[6] 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.

[7] 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**.

[8] 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.

[9] Two ARCs

[10] 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.

[11] 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 80
PROCEDURE AND METHOD OF PAYMENT
[Prior to 7/1/83, Social Services[770] Ch 80]

441—80.1(249A) The fiscal agent function in medical assistance. Rescinded IAB 5/25/05, effective 7/1/05.

441—80.2(249A) Submission of claims. Providers of medical and remedial care participating in the program shall submit claims for services rendered to the Iowa Medicaid enterprise on at least a monthly basis. All nursing facilities and providers of home- and community-based services shall submit claims for services after end of the calendar month in which the services are provided. Following audit of the claim, the Iowa Medicaid enterprise will make payment to the provider of care.

80.2(1) Electronic submission. Providers are encouraged to submit claims electronically whenever possible.

a. Ambulance service providers may bill electronically only when the procedures performed are identified by codes based on the ones that Medicare recognizes as emergency and support medical necessity without a review by the Iowa Medicaid enterprise.

b. When filing electronic claims, pharmacies shall use the format prescribed by the National Council for Prescription Drug Programs.

c. Claims submitted electronically after implementation of the Health Insurance Portability and Accountability Act of 1996 shall be filed on the Accredited Standards Committee (ASC) X12N 837 transaction, Health Care Claim. The department shall send all providers written notice when the Act is implemented.

(1) Providers listed as filing claims on Form CMS-1500 or on the Claim for Targeted Medical Care shall file claims on the professional version of the Health Care Claim.

(2) Providers listed as filing claims on Form CMS-1450 or on the Iowa Medicaid Long-Term Care Claim shall file the institutional version of the Health Care Claim.

(3) Dentists shall file the dental version of the Health Care Claim.

(4) Pharmacists providing drugs and injections shall use the format prescribed by the National Council for Prescription Drug Programs.

d. If a claim submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3969, Claim Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3969 the attachment control number submitted on the ASC X12N 837 electronic transaction.

80.2(2) Claim forms. Claims for payment for services provided recipients shall be submitted on Form CMS-1500, Health Insurance Claim Form, except as noted below.

a. The following providers shall submit claims on Form UB-04, CMS-1450:

(1) Home health agencies providing services other than home- and community-based services.

(2) Hospitals providing inpatient care or outpatient services, including inpatient psychiatric hospitals.

(3) Psychiatric medical institutions for children.

(4) Rehabilitation agencies.

(5) Hospice providers.

(6) Medicare-certified nursing facilities.

(7) Nursing facilities for the mentally ill.

(8) Special population nursing facilities as defined in rule 441—81.6(249A).

(9) Out-of-state nursing facilities.

b. All other nursing facilities and intermediate care facilities for the mentally retarded shall file claims on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

c. Pharmacies shall submit claims on the Universal Pharmacy Claim Form when filing paper claims.

d. Dentists shall submit claims on the dental claim form approved by the American Dental Association.

e. Rescinded IAB 8/1/07, effective 9/5/07.

f. Providers of home- and community-based waiver services, including home health agencies, shall submit claims on Form 470-2486, Claim for Targeted Medical Care. In the event of the death of the member, the case manager or service worker shall sign and date the claim form if the services were delivered.

g. Case management providers shall submit claims on Form 470-2486, Claim for Targeted Medical Care, for services provided pursuant to 441—Chapter 90 and on FACS-generated claims for services provided pursuant to 441—Chapter 186.

h. Providers billing claims for Medicare beneficiaries that do not cross over electronically to the Iowa Medicaid enterprise must submit the following electronically:

(1) Form UB-04 along with the Explanation of Medicare Benefits (EOMB); and

(2) Form CMS-1500 along with the Explanation of Medicare Benefits (EOMB).

80.2(3) Providers shall purchase their supplies of forms CMS-1450 and CMS-1500 for use in billing.

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

[**ARC 9403B**, IAB 3/9/11, effective 5/1/11; **ARC 9724B**, IAB 9/7/11, effective 9/1/11; **ARC 9889B**, IAB 11/30/11, effective 1/4/12; **ARC 2165C**, IAB 9/30/15, effective 12/1/15; **ARC 3159C**, IAB 7/5/17, effective 7/1/17]

441—80.3(249A) Payment from other sources.

80.3(1) *Payments deducted.* The amount of any payment made directly to the provider of care by the recipient, relatives, or any source shall be deducted from the established cost standard for the service provided to establish the amount of payment to be made by Iowa Medicaid.

80.3(2) *Third-party liability.* When a third-party liability for medical expenses exists, this resource shall be utilized before the Medicaid program makes payment unless:

a. The department pays the total amount allowed under the Medicaid payment schedule and then seeks reimbursement from the liable third party. This "pay and chase" provision applies to claims for:

(1) Prenatal care,

(2) Preventive pediatric services, and

(3) All services provided to a person for whom there is court-ordered medical support.

b. Otherwise authorized by the department.

80.3(3) *Recovery from third parties legally responsible to pay for health care.* Parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service shall:

a. Respond to any inquiry by the state regarding a claim for payment for any health care item or service that is submitted no later than three years after the date of the provision of the item or service.

b. Agree not to deny any claim submitted by the state solely because of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point of sale that is the basis of the claim, if both of the following conditions are met:

(1) The claim is submitted to the entity by the state within the three-year period beginning on the date on which the item or service was furnished.

(2) Any action by the state to enforce its rights with respect to the claim is commenced within six years of the date that the claim was submitted by the state.

c. Reimburse the Medicaid program within 90 days of the request for repayment.

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

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09]

441—80.4(249A) Time limit for submission of claims and claim adjustments.

80.4(1) *Submission of claims.* Payment will not be made on any claim when the amount of time that has elapsed between the date the service was rendered and the date the initial claim is received by the Iowa Medicaid enterprise exceeds 365 days. The department shall consider claims submitted beyond the

365-day limit for payment only if retroactive eligibility on newly approved cases is made that exceeds 365 days or if attempts to collect from a third-party payer delay the submission of a claim. In the case of retroactive eligibility, the claim must be received within 365 days of the first notice of eligibility by the department.

80.4(2) *Claim adjustments and resubmissions.* A provider's request for an adjustment to a paid claim or resubmission of a denied claim must be received by the Iowa Medicaid enterprise within 365 days from the date the claim was last adjudicated in order to have the adjustment or resubmission considered. In no case will a claim be paid if the claim is received beyond two years from the date of service.

80.4(3) *Definition.* For purposes of this rule, a claim is "received" when entered into the department's payment system with an action of pay, deny, or suspend. Any claim returned to the provider without such action is not "received."

This rule is intended to implement Iowa Code sections 249A.3, 249A.4 and 249A.12.

[**ARC 1155C**, IAB 10/30/13, effective 1/1/14]

441—80.5(249A) Authorization process.

80.5(1) *Identification cards.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to members for use in securing medical and health services available under the program except as provided in 441—76.6(249A).

a. The department shall issue the Medical Assistance Eligibility Card:

(1) When the member's eligibility is initially determined.

(2) Annually thereafter.

(3) Upon the member's request for replacement of a lost, stolen, or damaged card.

b. The Medical Assistance Eligibility Card is valid only for months in which the member has established eligibility, as indicated on the department's eligibility verification system (ELVS). Payment will be made for services provided to an ineligible person when ELVS indicates that the person was eligible for the period in which the service was provided.

80.5(2) *Third-party liability.* Rescinded IAB 2/11/09, effective 3/18/09.

[**ARC 7547B**, IAB 2/11/09, effective 3/18/09]

441—80.6(249A) Payment to provider—exception. Payments for medical services may be made only to the provider of the services except as provided below:

80.6(1) *Medical assistance corrective payments.* Payment may be made to the client or county relief agency in accordance with rule 441—75.8(249A).

80.6(2) *Assignment.* Payment may be made in accordance with an assignment to a county for medical services received while the recipient was receiving interim assistance or while an appeal of a denial of medical assistance was pending.

80.6(3) *Business agent of provider.* Payment may be made to a business agent that furnishes statements and receives payments in the name of the provider if the agent's compensation is:

a. Related to the cost of processing the billing.

b. Not related on a percentage or other basis to the amount that is billed or collected.

c. Not dependent upon the collection of the payment.

441—80.7(249A) Health care data match program. As a condition of doing business in Iowa, health insurers shall provide, upon the request of the state, information with respect to individuals who are eligible for or are provided medical assistance under the state's medical assistance state plan to determine (1) during what period the member or the member's spouse or dependents may be or may have been covered by a health insurer and (2) the nature of the coverage that is or was provided by the health insurer. This requirement applies to self-insured plans, group health plans as defined in the federal Employee Retirement Income Security Act of 1974 (Public Law 93-406), service benefit plans, managed care organizations, pharmacy benefits managers, and other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

80.7(1) *Agreement required.* The parties shall sign a data use agreement for the purposes of this rule. The agreement shall prescribe the manner in which information shall be provided to the department of human services and the acceptable uses of the information provided.

a. The initial provision of data shall include the data necessary to enable the department to match covered persons and identify third-party payers for the two-year period before the initial provision of the data. The data shall include the name, address, and identifying number of the plan.

b. Ongoing monthly matches may be limited to changes in the data previously provided, including additional covered persons, with the effective dates of the changes.

80.7(2) *Agreement form.*

a. An agreement with the department shall be in substantially the same form as Form 470-4415, Agreement for Use of Data.

b. An agreement with the department's designee shall be in a form approved by the designee, which shall include privacy protections equivalent to those provided in Form 470-4415, Agreement for Use of Data.

80.7(3) *Confidentiality of data.* The exchange of information carried out under this rule shall be consistent with all laws, regulations, and rules relating to the confidentiality or privacy of personal information or medical records, including but not limited to:

a. The federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191; and

b. Regulations promulgated in accordance with that Act and published in 45 CFR Parts 160 through 164.

[**ARC 1070C**, IAB 10/2/13, effective 10/1/13]

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

[Filed March 11, 1970; amended September 5, 1973]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed 12/9/76, Notice 11/3/76—published 12/29/76, effective 2/2/77]
[Filed 8/2/79, Notice 5/30/79—published 8/22/79, effective 9/26/79]
[Filed 1/28/82, Notice 11/11/81—published 2/17/82, effective 4/1/82]
[Filed 4/29/82, Notice 12/9/81—published 5/26/82, effective 7/1/82]
[Filed emergency 5/20/83—published 6/8/83, effective 6/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed emergency 5/31/84 after Notice 4/11/84—published 6/20/84, effective 7/1/84]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed 4/28/86, Notice 2/26/86—published 5/21/86, effective 7/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 9/2/88, Notice 6/29/88—published 9/21/88, effective 11/1/88]
[Filed emergency 11/23/88 after Notices 7/13/88, 9/21/88—published 12/14/88, effective 1/1/89]
[Filed emergency 12/8/88 after Notices 10/19/88, 11/2/88—published 12/28/88, effective 1/1/89]
[Filed 7/14/89, Notices 4/19/89, 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 9/15/89, Notice 8/9/89—published 10/4/89, effective 12/1/89]
[Filed emergency 12/15/89 after Notice 10/4/89—published 1/10/90, effective 1/1/90]
[Filed 4/13/90, Notice 11/29/90—published 5/2/90, effective 8/1/90]
[Filed 7/13/90, Notice 5/30/90—published 8/8/90, effective 10/1/90]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed emergency 1/17/91—published 2/6/91, effective 2/1/91]
[Filed 3/14/91, Notice 2/6/91—published 4/3/91, effective 6/1/91]
[Filed 8/8/91, Notice 6/26/91—published 9/4/91, effective 11/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed emergency 1/16/92 after Notice 11/29/91—published 2/5/92, effective 3/1/92]

[Filed 3/12/92, Notice 2/5/92—published 4/1/92, effective 7/1/92]
[Filed 1/14/93, Notice 11/11/92—published 2/3/93, effective 4/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed 4/14/94, Notice 2/16/94—published 5/11/94, effective 7/1/94]
[Filed 4/11/97, Notice 2/12/97—published 5/7/97, effective 7/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 9/1/97]
[Filed 6/8/00, Notice 4/19/00—published 6/28/00, effective 8/2/00]
[Filed emergency 12/14/00 after Notice 9/20/00—published 1/10/01, effective 1/1/01]
[Filed 12/14/00, Notice 11/1/00—published 1/10/01, effective 3/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01][◊]
[Filed 7/11/01, Notice 5/16/01—published 8/8/01, effective 10/1/01]
[Filed 12/12/01, Notice 7/11/01—published 1/9/02, effective 3/1/02]
[Filed emergency 1/9/02 after Notice 11/14/01—published 2/6/02, effective 2/1/02]
[Filed 2/14/02, Notice 1/9/02—published 3/6/02, effective 5/1/02]
[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03]
[Filed 5/16/03, Notice 4/2/03—published 6/11/03, effective 7/16/03]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed 5/16/07, Notice 2/14/07—published 6/6/07, effective 8/1/07]
[Filed 7/12/07, Notice 5/23/07—published 8/1/07, effective 9/5/07]
[Filed ARC 7547B (Notice ARC 7355B, IAB 11/19/08), IAB 2/11/09, effective 3/18/09]
[Filed ARC 9403B (Notice ARC 9170B, IAB 10/20/10), IAB 3/9/11, effective 5/1/11]
[Filed Emergency ARC 9724B, IAB 9/7/11, effective 9/1/11]
[Filed ARC 9889B (Notice ARC 9725B, IAB 9/7/11), IAB 11/30/11, effective 1/4/12]
[Filed Emergency After Notice ARC 1070C (Notice ARC 0909C, IAB 8/7/13), IAB 10/2/13, effective 10/1/13]
[Filed ARC 1155C (Notice ARC 0912C, IAB 8/7/13), IAB 10/30/13, effective 1/1/14]
[Filed ARC 2165C (Notice ARC 2061C, IAB 7/22/15), IAB 9/30/15, effective 12/1/15]
[Filed Emergency ARC 3159C, IAB 7/5/17, effective 7/1/17]

◊ Two or more ARCs

CHAPTER 83
MEDICAID WAIVER SERVICES

PREAMBLE

Medicaid waiver services are services provided to maintain persons in their own homes or communities who would otherwise require care in a medical institution, including support for persons to seek and maintain employment in the community. Provision of these services must be cost-effective. Services are limited to certain targeted client groups for whom a federal waiver has been requested and approved. Services provided through the waivers are not available to other Medicaid recipients as the services are beyond the scope of the Medicaid state plan.
[**ARC 2471C**, IAB 3/30/16, effective 5/4/16]

DIVISION I—HCBS HEALTH AND DISABILITY WAIVER SERVICES

441—83.1(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Blind individual" means an individual who has a central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of health and disability waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Disabled person" means an individual 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. A child under the age of 18 is considered disabled if the child suffers a medically determinable physical or mental impairment of comparable severity.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

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

"Intermittent homemaker service" means homemaker service provided from one to three hours a day for not more than four days per week.

"Intermittent respite service" means respite service provided from one to three times a week.

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

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility or an intermediate care facility for persons with an intellectual disability which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

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

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

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

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

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

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

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

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

a. A physician order for all skilled services.

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

c. An individualized care plan that identifies support needs.

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

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

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

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Substantial gainful activity" means productive activities which add to the economic wealth, or produce goods or services to which the public attaches a monetary value.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is 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 or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.2(249A) Eligibility. To be eligible for health and disability waiver services, a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.2(1) *Eligibility criteria.*

a. The person must be under the age of 65 and blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department.

Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act.

b. The person must be ineligible for Supplemental Security Income (SSI) if the person is 21 years of age or older, except that persons who are receiving health and disability waiver services upon reaching the age of 21 may continue to be eligible regardless of SSI eligibility until they reach the age of 25.

c. Persons shall meet the eligibility requirements of the supplemental security income program except for the following:

(1) The person is under 18 years of age, unmarried and not the head of a household and is ineligible for supplemental security income because of the deeming of the parent's(s') income.

(2) The person is married and is ineligible for supplemental security income because of the deeming of the spouse's income or resources.

(3) The person is ineligible for supplemental security income due to excess income and the person's income does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

(4) The person is under 18 years of age and is ineligible for supplemental security income because of excess resources.

d. The person must be certified as being in need of nursing facility or skilled nursing facility level of care or as being in need of care in an intermediate care facility for persons with an intellectual disability, based on information submitted on a completed information submission tool Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 to 64 and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available upon request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The member's designated case manager shall use the completed assessment to develop the comprehensive service plan as specified in rule 441—90.5(249A).

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

(3) Health and disability waiver services will not be provided when the person is an inpatient in a medical institution.

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

e. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician or a physician assistant.

f. The person must meet income and resource guidelines for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

g. The person must have service needs that can be met by this waiver program. At a minimum a person must receive one billable unit of service under the waiver per calendar quarter.

h. To be eligible for the consumer choices option as set forth in 441—subrule 78.34(13), a person cannot be living in a residential care facility.

83.2(2) *Need for services.*

a. The member shall have a service plan approved by the department which is developed by the designated case manager. This service plan must be completed prior to services provision and annually thereafter.

The designated case manager shall establish the interdisciplinary team for the member and, with the team, identify the member's need for service based on the member's needs and desires as well as the availability and appropriateness of services, using the following criteria:

(1) This service plan shall be based, in part, on information in the completed information submission tool listed in paragraph 83.2(1)*"d"* and other supporting documentation as relevant. The designated case manager shall have a face-to-face visit with the member at least quarterly.

(2) Service plans for persons aged 20 or under shall be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. The designated case manager shall list all nonwaiver Medicaid services in the service plan.

(3) Service plans for persons aged 20 or under that include home health or nursing services shall not be approved until a home health agency has made a request to cover the member's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the health and disability waiver services, excluding the cost of home and vehicle modification services, shall not exceed the established aggregate monthly cost for level of care as follows:

Skilled level of care	Nursing level of care	ICF/ID
$2,792.65	$959.50	$3,742.93

For members eligible for SSI who remain eligible for health and disability waiver services until the age of 25 because they are receiving health and disability waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the member would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

c. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker or targeted case manager. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.3(249A) Application.

83.3(1) *Application for HCBS health and disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.3(2) *Application and services program limit.* The number of persons who may be approved for the HCBS health and disability waiver shall be subject to the number of members to be served as set forth in the federally approved HCBS health and disability waiver. The number of members to be served is set forth at the time of each five-year renewal of the waiver or in amendments to the waiver approved by the Centers for Medicare and Medicaid Services (CMS). When the number of applicants exceeds the number of members specified in the approved waiver, the applicant's name shall be placed on a waiting list maintained by the bureau of long-term care.

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the applicant.

(3) A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(4) Once a payment slot is assigned, the county department office shall give written notice to the applicant. The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the department shall enter persons on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later.

(2) Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date a request as specified in 83.3(2)*"a"*(2) is received by the department.

(3) In the event that more than one application is received at one time, persons shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(4) Applicants who do not fall within the available slots shall have their application rejected, and their names shall be maintained on the waiting list. They shall be contacted to reapply as slots become available based on their order on the waiting list so that the number of approved persons on the program is maintained. The bureau of long-term care shall contact the county department office when a slot becomes available.

(5) Once a payment slot is assigned, the county department office shall give written notice to the person within five working days. The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

c. The county department office shall notify the bureau of long-term care within five working days of the receipt of an application and of any action on or withdrawal of an application.

83.3(3) *Approval of application.*

a. Applications for the HCBS health and disability waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) An application has been filed and is pending for federal supplemental security income benefits.

(2) The application is pending because the department has not received information which is beyond the control of the client or the department.

(3) The application is pending due to the disability determination process performed through the department.

(4) The application is pending because a level of care determination has not been made although the required assessment has been submitted to the IME medical services unit.

(5) The application is pending because the required assessment has not been completed. When a determination is not completed 90 days from the date of application due to the lack of a completed assessment, the application shall be denied.

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

c. An applicant must be given the choice between HCBS health and disability waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A member may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the member is in a medical institution (hospital or nursing facility) or residential facility. Services may not be simultaneously reimbursed for the same time period as Medicaid or other Medicaid waiver services.

83.3(4) *Effective date of eligibility.*

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

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

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

d. Eligibility continues until the member has been in a medical institution for 30 consecutive days for other than respite care. Members who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from health and disability waiver services and reviewed for eligibility for other Medicaid coverage groups. The member will be notified of that decision through Form 470-0602, Notice of Decision. If the member returns home before the effective date of the notice of decision and the member's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.3(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of health and disability waiver services or other Medicaid services, as applicable.

83.4(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.4(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker or targeted case manager for health and disability waiver services, Medicaid shall make no payments to health and disability waiver service providers. However, Medicaid shall make payments to other medical vendors, as applicable.

83.4(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

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

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

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

83.5(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.6(249A) Allowable services. Services allowable under the health and disability waiver are homemaker, home health, adult day care, respite care, nursing, counseling, consumer-directed attendant care, interim medical monitoring and treatment, home and vehicle modification, personal emergency response system, home-delivered meals, nutritional counseling, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.34(249A).
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13]

441—83.7(249A) Service plan. A service plan shall be prepared for health and disability waiver members in accordance with 441—paragraph 90.5(1)*"b."* Service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.7(1) The service plan shall include the frequency of the health and disability waiver services and the types of providers who will deliver the services.

83.7(2) The service plan shall indicate whether the member has elected the consumer choices option. If the member has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the member; and

b. The financial management service selected by the member.

83.7(3) The service plan shall also list all nonwaiver Medicaid services.

83.7(4) The service plan shall identify a plan for emergencies and the supports available to the member in an emergency.
[**ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.8(249A) Adverse service actions.

83.8(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the aggregate monthly costs established in 83.2(2)*"b,"* or are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

83.8(2) Termination. A particular service may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the health and disability waiver service for the person exceed the aggregate monthly costs established in 83.2(2)*"b."*

c. The member receives care in a hospital, nursing facility, or intermediate care facility for persons with an intellectual disability for 30 days in any one stay for purposes other than respite care.

d. The member receives health and disability waiver services and the physical or mental condition of the member requires more care than can be provided in the member's own home as determined by the designated case manager.

e. Service providers are not available.

83.8(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0757C**, IAB 5/29/13, effective 8/1/13; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.9(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234). The applicant or recipient is entitled to have a review of the level of care determination by the IME medical services unit by sending a letter requesting a review to the IME medical services unit. If dissatisfied with that decision, the applicant or recipient may file an appeal with the department.

441—83.10(249A) County reimbursement. Rescinded IAB 4/9/97, effective 6/1/97.

441—83.11(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.12 to **83.20** Reserved.

DIVISION II—HCBS ELDERLY WAIVER SERVICES

441—83.21(249A) Definitions.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient income that the person must contribute to the cost of elderly waiver services exclusive of medical vendor payments before Medicaid will participate.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Interdisciplinary team" means a collection of persons with varied professional backgrounds who develop one plan of care to meet a client's need for services.

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

"Medical institution" means a nursing facility which has been approved as a Medicaid vendor.

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

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

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

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

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

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

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

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

a. A physician order for all skilled services.

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

c. An individualized care plan that identifies support needs.

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

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

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

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an individual, institution, corporation, or public or private agency which is 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 or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.22(249A) Eligibility. To be eligible for elderly waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.22(1) *Eligibility criteria.* All of the following criteria must be met. The person must be:

a. Sixty-five years of age or older.

b. A resident of the state of Iowa.

c. Eligible for Medicaid as if in a medical institution pursuant to 441—Chapter 75. When a husband and wife who are living together both apply for the waiver, income and resource guidelines as specified at 441—paragraphs 75.5(2)*"b"* and 75.5(4)*"c"* shall be applied.

d. Certified as being in need of the intermediate or skilled level of care based, in part, on information submitted on the interRAI - Home Care (HC). The interRAI - Home Care (HC) is available on request from IME medical services unit and other supporting documentation as relevant. Copies of the completed interRAI - Home Care (HC) for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The assessment shall be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care. The IME medical services unit shall be responsible for determination of the initial level of care.

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

(3) Elderly waiver services will not be provided when the person is an inpatient in a medical institution.

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

e. Determined to need services as described in subrule 83.22(2).

f. Rescinded IAB 10/11/06, effective 10/1/06.

g. For the consumer choices option as set forth in rule 441—subrule 78.37(16), residing in a living arrangement other than a residential care facility.

83.22(2) *Need for services, service plan, and cost.*

a. Case management. Consumers under the elderly waiver shall receive case management services from a provider qualified pursuant to rule 441—77.29(249A). Case management services shall be provided as set forth in rules 441—90.5(249A) and 441—90.8(249A).

b. Interdisciplinary team. The case manager shall establish an interdisciplinary team for the consumer.

(1) Composition. The interdisciplinary team shall include the case manager and the consumer and, if appropriate, the consumer's legal representative, family, service providers, and others directly involved in the consumer's care.

(2) Role. The team shall identify:

1. The consumer's need for services based on the consumer's needs and desires.
2. Available and appropriate services to meet the consumer's needs.
3. Health and safety issues for the consumer that indicate the need for an emergency plan, based on a risk assessment conducted before the team meeting.
4. Emergency backup support and a crisis response system to address problems or issues arising when support services are interrupted or delayed or when the consumer's needs change.

c. Service plan. An applicant for elderly waiver services shall have a service plan developed by a qualified provider of case management services under the elderly waiver.

(1) Services included in the service plan shall be appropriate to the problems and specific needs or disabilities of the consumer.

(2) Services must be the least costly available to meet the service needs of the member. The total monthly cost of the elderly waiver services exclusive of case management services shall not exceed the established monthly cost of the level of care. Aggregate monthly costs, excluding the cost of case management and home and vehicle modifications, are limited as follows:

Skilled level of care	Nursing level of care
$2,792.65	$1,365.78

(3) The service plan must be completed before services are provided.

(4) The service plan must be reviewed at least annually and when there is any significant change in the consumer's needs.

d. Content of service plan. The service plan shall include the following information based on the consumer's current assessment and service needs:

(1) Observable or measurable individual goals.

(2) Interventions and supports needed to meet those goals.

(3) Incremental action steps, as appropriate.

(4) The names of staff, people, businesses, or organizations responsible for carrying out the interventions or supports.

(5) The desired individual outcomes.

(6) The identified activities to encourage the consumer to make choices, to experience a sense of achievement, and to modify or continue participation in the service plan.

(7) Description of any restrictions on the consumer's rights, including the need for the restriction and a plan to restore the rights. For this purpose, rights include maintenance of personal funds and self-administration of medications.

(8) A list of all Medicaid and non-Medicaid services that the consumer received at the time of waiver program enrollment that includes:

1. The name of the service provider responsible for providing the service.
2. The funding source for the service.
3. The amount of service that the consumer is to receive.

(9) Indication of whether the consumer has elected the consumer choice option and, if so, the independent support broker and the financial management service that the consumer has selected.

(10) The determination that the services authorized in the service plan are the least costly.

(11) A plan for emergencies that identifies the supports available to the consumer in situations for which no approved service plan exists and which, if not addressed, may result in injury or harm to the consumer or other persons or in significant amounts of property damage. Emergency plans shall include:

1. The consumer's risk assessment and the health and safety issues identified by the consumer's interdisciplinary team.

2. The emergency backup support and crisis response system identified by the interdisciplinary team.

3. Emergency, backup staff designated by providers for applicable services.

83.22(3) *Providers—standards.* Rescinded IAB 10/11/06, effective 10/1/06.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.23(249A) Application.

83.23(1) *Application for HCBS elderly waiver.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.23(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.23(3) *Approval of application.*

a. Applications for the elderly waiver program shall be processed in 30 days unless the worker can document difficulty in locating and arranging services or circumstances beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant must be given the choice between elderly waiver services and institutional care. The applicant, guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool specified in 83.22(1)*"d,"* indicating that the applicant has elected waiver services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.23(4) *Effective date of eligibility.*

a. The effective date of eligibility is the date on which the income eligibility and level of care determinations are completed.

b. Eligibility for persons whose income exceeds supplemental security income guidelines shall not exist until the persons require care in a medical institution 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.

c. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.22(249A). Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from elderly waiver services and reviewed for eligibility for other Medicaid coverage groups. The consumer will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the consumer's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

83.23(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.24(249A) Client participation. Persons must contribute their predetermined client participation to the cost of elderly waiver services.

83.24(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.24(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement established by the service worker, Medicaid will make no payments for elderly waiver service providers. However, Medicaid will make payments to other medical vendors.

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

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

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

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

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.26(249A) Allowable services. Services allowable under the elderly waiver are case management, adult day care, emergency response system, homemaker, home health aide, nursing, respite care, chore, home-delivered meals, home and vehicle modification, mental health outreach, transportation, nutritional counseling, assistive devices, senior companions, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.37(249A).

441—83.27(249A) Service plan. The service plan shall be completed jointly by the consumer, the elderly waiver case manager, and any other person identified by the consumer.

83.27(1) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.27(2) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.28(249A) Adverse service actions.

83.28(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the elderly waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.22(2)*"b,"* or are not met by services provided.

d. Needed services are not available or received from qualifying providers.

e. Rescinded IAB 3/2/94, effective 3/1/94.

83.28(2) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the elderly waiver services for the person exceed the aggregate monthly costs established in 83.22(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days in any one stay for purposes other than respite care.

d. The client receives elderly waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the case manager and the interdisciplinary team.

e. Service providers are not available.

83.28(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.29(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.30(249A) Enhanced services. When a household has one person receiving service in accordance with rules set forth in 441—Chapter 24 and another receiving elderly waiver services, the persons providing case management shall cooperate to make the best plan for both clients. When a person is eligible for services as set forth in 441—Chapter 24 and eligible for services under the elderly waiver, the person's primary diagnosis will determine which services shall be used.

441—83.31(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.32 to **83.40** Reserved.

DIVISION III—HCBS AIDS/HIV WAIVER SERVICES

441—83.41(249A) Definitions.

"AIDS" means a medical diagnosis of acquired immunodeficiency syndrome based on the Centers for Disease Control "Revision of the CDC Surveillance Case Definition for Acquired Immunodeficiency Syndrome," August 14, 1987, Vol. 36, No. 1S issue of "Morbidity and Mortality Weekly Report."

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Client participation" means the amount of the recipient's income that the person must contribute to the cost of AIDS/HIV waiver services exclusive of medical vendor payments before Medicaid will participate.

"Deeming" means the specified amount of parental or spousal income and resources considered in determining eligibility for a child or spouse according to current supplemental security income guidelines.

"Financial participation" means client participation and medical payments from a third party including veterans' aid and attendance.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"HIV" means a medical diagnosis of human immunodeficiency virus infection based on a positive HIV-related test.

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

"Medical institution" means a nursing facility or hospital which has been approved as a Medicaid vendor.

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

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

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

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

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

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

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

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

a. A physician order for all skilled services.

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

c. An individualized care plan that identifies support needs.

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

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

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

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Third-party payments" means payments from an attorney, individual, institution, corporation, or public or private agency which is 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 or a past or present recipient of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.42(249A) Eligibility. To be eligible for AIDS/HIV waiver services a person must meet certain eligibility criteria and be determined to need a service(s) allowable under the program.

83.42(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Be diagnosed by a physician as having AIDS or HIV infection.

b. Be certified in need of the level of care that, but for the waiver, would otherwise be provided in a nursing facility or hospital based, in part, on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

(1) The assessment as listed in 83.42(1)*"b"* shall be completed when the person applies for waiver services, upon request to report a significant change in the person's condition, and annually for reassessment of the person's level of care.

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

(3) AIDS/HIV waiver services shall not be provided when the person is an inpatient in a medical institution.

c. Be eligible for medical assistance under SSI, SSI-related, FMAP, or FMAP-related coverage groups; medically needy at hospital level of care; or a special income level (300 percent group); or become eligible through application of the institutional deeming rules.

d. Require, and use at least quarterly, one service available under the waiver as determined through an evaluation of need described in subrule 83.42(2).

e. Have service needs such that the costs of the waiver services are not likely to exceed the costs of care that would otherwise be provided in a medical institution.

f. Have income which does not exceed 300 percent of the maximum monthly payment for one person under supplemental security income.

g. For the consumer choices option as set forth in 441—subrule 78.38(9), not be living in a residential care facility.

83.42(2) *Need for services.*

a. The designated case manager shall review the assessment of the person's need for waiver services and determine the availability and appropriateness of services. This review shall be based, in part, on information in the completed information submission tool designated in 83.42(1)*"b"* and other supporting documentation as relevant.

b. The total monthly cost of the AIDS/HIV waiver services shall not exceed the established aggregate monthly cost for level of care. The monthly cost of AIDS/HIV waiver services cannot exceed the established limit of $1,876.80.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.43(249A) Application.

83.43(1) *Application for HCBS AIDS/HIV waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.43(2) *Application for services.* Rescinded IAB 12/6/95, effective 2/1/96.

83.43(3) *Approval of application.*

a. Applications for the HCBS AIDS/HIV waiver program shall be processed in 30 days unless one or more of the following conditions exist:

(1) The application is pending because the department has not received information, which is beyond the control of the client or the department.

(2) The application is pending because a level of care determination has not been made although the completed assessment has been submitted to the IME medical services unit.

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

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

c. An applicant must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The applicant, parent, guardian, or attorney in fact under a durable power of attorney for health care shall sign the assessment and indicate that the applicant has elected home- and community-based services.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

83.43(4) *Effective date of eligibility.*

a. The effective date of eligibility for the AIDS/HIV waiver for persons who are already determined eligible for Medicaid is the date on which the income and resource eligibility and level of care determinations are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations are completed.

c. Eligibility for the waiver continues until the recipient has been in a medical institution for 30 consecutive days for other than respite care or fails to meet eligibility criteria listed in rule 441—83.42(249A). Recipients who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be reviewed for eligibility for other Medicaid coverage groups and terminated from AIDS/HIV waiver services if found eligible under another coverage group. The recipient will be notified of that decision through Form 470-0602, Notice of Decision. If the consumer returns home before the effective date of the notice of decision and the person's condition has not substantially changed, the denial may be rescinded and eligibility may continue.

d. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom the eligibility factors set forth in 441—subrule 75.1(7) and, for married persons, in rule 441—75.5(249A) have been satisfied is the date on which the income eligibility and level of care determinations are completed but shall not be earlier than the first of the month following the date of application.

83.43(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.44(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of AIDS/HIV waiver services or other Medicaid services, as applicable.

83.44(1) *Maintenance needs of the individual.* The maintenance needs of the individual shall be computed by deducting an amount which is 300 percent of the maximum monthly payment for one person under supplemental security income (SSI) from the client's total income.

83.44(2) *Limitation on payment.* If the amount of the financial participation equals or exceeds the reimbursement established by the service worker for AIDS/HIV services, Medicaid will make no payments to AIDS/HIV waiver service providers. Medicaid will, however, make payments to other medical vendors.

83.44(3) *Maintenance needs of spouse and other dependents.* Rescinded IAB 4/9/97, effective 6/1/97.

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

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

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

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.46(249A) Allowable services. Services allowable under the AIDS/HIV waiver are counseling, home health aide, homemaker, nursing care, respite care, home-delivered meals, adult day care, consumer-directed attendant care, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.38(249A).

441—83.47(249A) Service plan. A service plan shall be prepared for AIDS/HIV waiver consumers in accordance with rule 441—130.7(234) except that service plans for both children and adults shall be completed every 12 months or when there is significant change in the person's situation or condition.

83.47(1) The service plan shall include the frequency of the AIDS/HIV waiver services and the types of providers who will deliver the services.

83.47(2) The service plan shall indicate whether the consumer has elected the consumer choices option. If the consumer has elected the consumer choices option, the service plan shall identify:

a. The independent support broker selected by the consumer; and

b. The financial management service selected by the consumer.

83.47(3) Service plans for consumers aged 20 or under must be developed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

83.47(4) The service plan shall identify a plan for emergencies and the supports available to the consumer in an emergency.

441—83.48(249A) Adverse service actions.

83.48(1) Denial. An application for services shall be denied when it is determined by the department that:

a. The client is not eligible for or in need of services.

b. Except for respite care, the AIDS/HIV waiver services are not needed on a regular basis.

c. Service needs exceed the aggregate monthly costs established in 83.42(2)*"b"* or cannot be met by the services provided under the waiver.

d. Needed services are not available from qualified providers.

83.48(2) Termination. Participation in the AIDS/HIV waiver program may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"a," "b," "c," "d," "g,"* or *"h"* apply.

b. The costs of the AIDS/HIV waiver services for the person exceed the aggregate monthly costs established in 83.42(2)*"b."*

c. The client receives care in a hospital or nursing facility for 30 days or more in any one stay for purposes other than respite care.

d. The client receives AIDS/HIV waiver services and the physical or mental condition of the client requires more care than can be provided in the client's own home as determined by the service worker.

e. Service providers are not available.

83.48(3) Reduction of services shall apply as in 441—subrule 130.5(3), paragraphs *"a"* and *"b."*

441—83.49(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.50(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

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

441—83.51 to **83.59** Reserved.

DIVISION IV—HCBS INTELLECTUAL DISABILITY WAIVER SERVICES

441—83.60(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and one's ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home-living, social skills, community use, self-direction, safety, functional activities of daily living, leisure or work.

"Adult" means a person with an intellectual disability aged 18 or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with an intellectual disability aged 17 or under.

"Client participation" means the posteligibility amount of the consumer's income that persons eligible through a special income level must contribute to the cost of the home and community-based waiver service.

"Counseling" means face-to-face mental health services provided to the consumer and caregiver by a qualified intellectual disability professional (QIDP) to facilitate home management of the consumer and prevent institutionalization.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

"Intellectual disability" means a diagnosis of intellectual disability (intellectual developmental disorder), global developmental delay, or unspecified intellectual disability (intellectual developmental disorder) which shall be made only when the onset of the person's condition was during the developmental period and shall be based on an assessment of the person's intellectual functioning and level of adaptive skills. The diagnosis shall be made by a person who is a licensed psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person's adaptive skills. The diagnosis shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), published by the American Psychiatric Association.

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

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

sensory-taste, smell, tactile, academic skills, vocational skills, social/community skills, behavior, and health care.

"Intermittent supported community living service" means supported community living service provided not more than 52 hours per month.

"Maintenance needs" means costs associated with rent or mortgage, utilities, telephone, food and household supplies.

"Managed care" means a system that provides the coordinated delivery of services and supports that are necessary and appropriate, delivered in the least restrictive settings and in the least intrusive manner. Managed care seeks to balance three factors:

1. Achieving high-quality outcomes for participants.
2. Coordinating access.
3. Containing costs.

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

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified intellectual disability professional" means a person who has at least one year of experience working directly with persons with an intellectual disability or other developmental disabilities and who is one of the following:

1. A doctor of medicine or osteopathy.
2. A registered nurse.
3. An occupational therapist eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.
4. A physical therapist eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.
5. A speech-language pathologist or audiologist eligible for certification of Clinical Competence in Speech-Language Pathology or Audiology by the American Speech-Language Hearing Association

or another comparable body or who meets the educational requirements for certification and who is in the process of accumulating the supervised experience required for certification.

6. A psychologist with a master's degree in psychology from an accredited school.

7. A social worker with a graduate degree from a school of social work, accredited or approved by the Council on Social Work Education or another comparable body or who holds a bachelor of social work degree from a college or university accredited or approved by the Council of Social Work Education or another comparable body.

8. A professional recreation staff member with a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. A professional dietitian who is eligible for registration by the American Dietetics Association.

10. A human services professional who must have at least a bachelor's degree in a human services field including, but not limited to, sociology, special education, rehabilitation counseling and psychology.

"Related condition" means a severe, chronic disability that meets all the following conditions:

1. It is attributable to cerebral palsy, epilepsy, or any other condition, other than mental illness, found to be closely related to intellectual disability because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual disability and requires treatment or services similar to those required for a person with an intellectual disability.

2. It is manifested before the age of 22.

3. It is likely to continue indefinitely.

4. It results in substantial functional limitations in three or more of the following areas of major life activity:

- Self-care.
- Understanding and use of language.
- Learning.
- Mobility.
- Self-direction.
- Capacity for independent living.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

"SIS assessment" means the Supports Intensity Scale® assessment developed and licensed by the American Association on Intellectual and Developmental Disabilities for use in the assessment of the support and service needs of individuals.

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an attorney, individual, institution, corporation, insurance company, or public or private agency which is 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 or a past or present recipient of Medicaid.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2168C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.61(249A) Eligibility. To be eligible for HCBS intellectual disability waiver services a person must meet certain eligibility criteria and be determined to need a service(s) available under the program.

83.61(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of intellectual disability as defined in rule 441—83.60(249A). The diagnosis shall be initially established and recertified as follows:

Age	Initial application to HCBS intellectual disability waiver program	Recertification for persons with a diagnosis of moderate, severe or profound level of severity	Recertification for persons with a diagnosis of mild or unspecified level of severity
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of intellectual disability as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every six years and when a significant change occurs	After the initial psychological evaluation, substantiate a diagnosis of intellectual disability as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 years and above	Current psychological documentation substantiating a diagnosis of intellectual disability if the last testing date was (1) more than six years ago for an applicant with a diagnosis of mild or unspecified severity, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound level of severity	Psychological documentation substantiating a diagnosis of intellectual disability made since the member reached 22 years of age	Psychological documentation substantiating a diagnosis of intellectual disability every six years and whenever a significant change occurs

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups; eligible under the special income level (300 percent) coverage group; or become eligible through application of the institutional deeming rules or would be eligible for Medicaid if in a medical institution.

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

d. Be a recipient of the Medicaid case management services or be identified to receive Medicaid case management services immediately following program enrollment.

e. Have service needs that can be met by this waiver program. At a minimum, a consumer must receive one billable unit of service per calendar quarter under this program.

f. Have a service plan completed annually and approved by the department in accordance with rule 441—83.67(249A).

g. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

h. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

i. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

j. Choose HCBS intellectual disability waiver services rather than ICF/ID services.

k. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

l. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

m. For residential-based supported community living services, meet all of the following additional criteria:

(1) Be less than 18 years of age.

(2) Be preapproved as appropriate for residential-based supported community living services by the bureau of long-term care. Requests for approval shall be submitted in writing to the DHS Bureau of Long-Term Care, 1305 East Walnut Street, Des Moines, Iowa 50319-0114, and shall include the following:

1. Social history;

2. Case history that includes previous placements and service programs;

3. Medical history that includes major illnesses and current medications;

4. Current psychological evaluations and consultations;

5. Summary of all reasonable and appropriate service alternatives that have been tried or considered;

6. Any current court orders in effect regarding the child;

7. Any legal history;

8. Whether the child is at risk of out-of-home placement or the proposed placement would be less restrictive than the child's current placement for services;

9. Whether the proposed placement would be safe for the child and for other children living in that setting; and

10. Whether the interdisciplinary team is in agreement with the proposed placement.

(3) Either:

1. Be residing in an ICF/ID;

2. Be at risk of ICF/ID placement, as documented by an interdisciplinary team assessment pursuant to paragraph 83.61(2)*"a"*; or

3. Be a child whose long-term placement outside the home is necessary because continued stay in the home would be a detriment to the health and welfare of the child or the family, and all service options to keep the child in the home have been reviewed by an interdisciplinary team, as documented in the service file.

n. For day habilitation, be 16 years of age or older.

o. For the consumer choices option as set forth in 441—subrule 78.41(5), not be living in a residential care facility.

83.61(2) *Need for services.*

a. Applicants currently receiving Medicaid case management shall have the applicable staff coordinate with the department to arrange completion of Form 470-4694 for children under the age of five and, for all others, an SIS assessment.

b. Applicants not receiving services as set forth in paragraph 83.61(2)*"a"* shall have a department service worker or case manager:

(1) Arrange for completion of Form 470-4694 for children under the age of five and, for all others, an SIS assessment for the initial level of care determination;

(2) Establish an initial interdisciplinary team for HCBS intellectual disability waiver services; and

(3) With the initial interdisciplinary team, identify the applicant's needs and desires as well as the availability and appropriateness of services.

c. Applicants meeting other eligibility criteria who do not have a Medicaid case manager shall be referred to a Medicaid case manager.

d. Services shall not exceed the number of maximum units established for each service.

e. The cost of services shall not exceed unit expense maximums. Requests shall only be reviewed for funding needs exceeding the supported community living service unit cost maximum. Requests require special review by the department and may be denied as not cost-effective.

f. The case manager shall coordinate with the department for completion of Form 470-4694 for children under the age of five and, for all others, to arrange an SIS assessment for the initial level of care determination within 30 days from the date of the HCBS application unless the case manager can document difficulty in locating information necessary to arrange the assessment or other circumstances beyond the case manager's control.

g. At initial enrollment, the case manager shall establish an interdisciplinary team for each applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services. The Medicaid case manager shall complete an annual review thereafter. The following criteria shall be used for the initial and ongoing identification of need for services:

(1) The assessment shall be based on the results of the most recent Form 470-4694 for children under the age of five and, for all others, the SIS assessment or of the SIS contractor's off-year review.

(2) Service plans must be developed or reviewed to reflect use of all appropriate nonwaiver Medicaid services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall be approved (signed and dated) by the designee of the bureau of long-term care. The service worker, department QIDP, or Medicaid case manager shall attach a written request for a variance from the maximum for intermittent supported community living with a summary of services and service costs. The written request for the variance shall provide a rationale for requesting supported community living beyond intermittent. The rationale shall contain sufficient information for the designee to make a decision regarding the need for supported community living beyond intermittent.

h. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

83.61(3) *HCBS intellectual disability waiver program limit.* The number of persons receiving HCBS intellectual disability waiver services in the state shall be limited to the number of payment slots provided in the HCBS intellectual disability waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit as deemed necessary.

a. The payment slots are available on a statewide basis. These slots shall be available based on the prioritized need of an applicant pursuant to subrule 83.61(4).

b. When services are denied because the limit is reached, a notice of decision denying service based on the limit and stating that the person's name will be put on a waiting list shall be sent to the person by the department.

83.61(4) *Securing a payment slot.* The department shall determine if a payment slot is available for each applicant for the HCBS intellectual disability waiver.

a. A payment slot shall be assigned to the applicant upon confirmation of an available slot.

(1) Once a payment slot is assigned, the department shall give written notice to the applicant.

(2) The department shall hold the payment slot for the applicant as long as reasonable efforts are being made to arrange services and the applicant has not been determined to be ineligible for the program. If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next person on the waiting list, if applicable. The applicant originally assigned the slot must reapply for a new slot.

b. If no payment slot is available, the applicant shall be placed on a statewide priority waiting list. The department shall assess each applicant to determine the applicant's priority need. The assessment shall be made for all applicants who are on a waiting list maintained by the state or a county on September 30, 2011, and for all new applications received on or after October 1, 2011.

(1) Emergency need criteria are as follows:

1. The usual caregiver has died or is incapable of providing care, and no other caregivers are available to provide needed supports.

2. The applicant has lost primary residence or will be losing housing within 30 days and has no other housing options available.

3. The applicant is living in a homeless shelter and no alternative housing options are available.

4. There is founded abuse or neglect by a caregiver or others living within the home of the applicant, and the applicant must move from the home.

5. The applicant cannot meet basic health and safety needs without immediate supports.

(2) Urgent need criteria are as follows:

1. The caregiver will need support within 60 days in order for the applicant to remain living in the current situation.

2. The caregiver will be unable to continue to provide care within the next 60 days.

3. The caregiver is 55 years of age or older and has a chronic or long-term physical or psychological condition that limits the ability to provide care.

4. The applicant is living in temporary housing and plans to move within 31 to 120 days.

5. The applicant is losing permanent housing and plans to move within 31 to 120 days.

6. The caregiver will be unable to be employed if services are not available.

7. There is a potential risk of abuse or neglect by a caregiver or others within the home of the applicant.

8. The applicant has behaviors that put the applicant at risk.

9. The applicant has behaviors that put others at risk.

10. The applicant is at risk of facility placement when needs could be met through community-based services.

(3) Applicants who meet an emergency need criterion shall be placed on the priority waiting list based on the total number of criteria in subparagraph 83.61(4)*"b"*(1) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(4) Applicants who meet an urgent need criterion shall be placed on the priority waiting list after applicants who meet emergency need criteria. The position on the waiting list shall be based on the total number of criteria in subparagraph 83.61(4)*"b"*(2) that are met. If applicants meet an equal number of criteria, the position on the waiting list shall be based on the date of application and the age of the applicant. The applicant who has been on the waiting list longer shall be placed higher on the waiting list. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(5) Applicants who do not meet emergency or urgent need criteria shall be placed lower on the waiting list than the applicants meeting urgent need criteria, based on the date of application. If the application date is the same, the older applicant shall be placed higher on the waiting list.

(6) Applicants shall remain on the waiting list until a payment slot has been assigned to them for use, they withdraw from the list, or they become ineligible for the waiver. If there is a change in an applicant's need, the applicant may contact the local department office and request that a new assessment be completed. The outcome of the assessment shall determine placement on the waiting list as directed in this subrule.

c. To maintain the approved number of members in the program, persons shall be selected from the waiting list as payment slots become available, based on their priority order on the waiting list.

(1) Once a payment slot is assigned, the department shall give written notice to the person within five working days.

(2) The department shall hold the payment slot for 30 days for the person to file a new application. If an application has not been filed within 30 days, the slot shall revert for use by the next person on the waiting list, if applicable. The person originally assigned the slot must reapply for a new slot.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 2050C**, IAB 7/8/15, effective 7/1/15; **ARC 2168C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.62(249A) Application.

83.62(1) *Application for HCBS intellectual disability waiver services.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.62(2) Rescinded IAB 6/5/96, effective 8/1/96.

83.62(3) *Approval of application.*

a. Applications for the HCBS intellectual disability waiver program shall be processed in 30 days unless the case manager or worker can document difficulty in locating and arranging services or other circumstance beyond the worker's control. In these cases a decision shall be made as soon as possible.

b. Decisions shall be mailed or given to the applicant on the date when both service and income maintenance eligibility determinations are completed.

c. An applicant shall be given the choice between HCBS waiver services and ICF/ID care. The case manager or worker shall have the consumer or legal representative indicate the consumer's choice of care.

d. HCBS intellectual disability waiver services provided before eligibility for the waiver is approved shall not be reimbursed by the HCBS waiver program.

e. Services provided when the person is a consumer of group foster care services or is an inpatient in a medical institution shall not be reimbursed.

f. HCBS intellectual disability waiver services are not available in conjunction with other Medicaid waiver services or group foster care services.

g. Rescinded IAB 5/6/09, effective 7/1/09.

83.62(4) *Effective date of eligibility.*

a. Deeming of parental income and resources ceases the month following the month in which a person requires care in a medical institution.

b. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet the criteria set forth in rule 441—83.61(249A).

c. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet criteria set forth in rule 441—83.61(249A) and when the eligibility factor set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A) have been satisfied.

d. Eligibility continues until the consumer fails to meet eligibility criteria listed in rule 441—83.61(249A). Consumers who are inpatients in a medical institution for 30 consecutive days shall receive a review by the interdisciplinary team to determine additional inpatient needs for possible termination from the HCBS program. Consumers shall be reviewed for eligibility under other Medicaid coverage groups. The consumer or legal representative shall participate in the review and receive formal notification of that decision through Form 470-0602, Notice of Decision.

If the consumer returns home before the effective date of the notice of decision and the consumer's needs can still be met by the HCBS waiver services, the denial may be rescinded and eligibility may continue.

e. Eligibility and service reimbursement are effective through the last day of the month of the previous annual service plan staffing meeting and the corresponding long-term care need determination.

83.62(5) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver applicant met the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2168C**, IAB 9/30/15, effective 11/4/15]

441—83.63(249A) Client participation. Persons who are eligible under the 300 percent group must contribute a predetermined client participation amount to the costs of the services.

83.63(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the individual which is 300 percent of the maximum SSI grant for an individual from the client's total income.

83.63(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific HCBS waiver service, Medicaid will make no payments for the HCBS waiver service. However, Medicaid will make payments to other medical vendors.

441—83.64(249A) Redetermination. A redetermination of nonfinancial eligibility for HCBS intellectual disability waiver services shall be completed at least once every 12 months. In years in which an SIS assessment is not completed for an individual five years of age or older, the SIS contractor shall conduct a review in collaboration with the case manager, documenting any changes in the member's functional status since the previous SIS or other full assessment. Form 470-4694 shall be completed annually for children under the age of five.

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

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

83.64(2) The managed care organization must submit documentation to the IME medical services unit for all reassessments, performed at least annually, which indicate a change in the member's level of care. The IME medical services unit shall make a final determination for any reassessments which

indicate a change in the level of care. If the level of care reassessment indicates no change in level of care, the member is approved to continue at the already established level of care.
[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 2168C**, IAB 9/30/15, effective 11/4/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS intellectual disability waiver are supported community living, respite, personal emergency response system, nursing, home health aide, home and vehicle modification, supported employment, consumer-directed attendant care, interim medical monitoring and treatment, transportation, adult day care, day habilitation, prevocational services, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.41(249A).
[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS intellectual disability waiver consumer.

83.67(1) *Development.* The service plan shall be developed by the interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager or service worker, service providers, and others directly involved.

83.67(2) *Retention.* The service plan shall be stored by the case manager for a minimum of three years.

83.67(3) *Interdisciplinary team meeting.* The interdisciplinary team meeting shall be conducted before the current service plan expires.

83.67(4) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of the consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The name of the service provider responsible for providing each service.

e. The service funding source.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.67(5) *Documentation.* The Medicaid case manager shall ensure that the consumer's case file contains the consumer's service plan and documentation supporting the diagnosis of mental retardation.

83.67(6) *Approval of plan.* The plan shall be approved through the Individualized Services Information System (ISIS). Services shall be entered into ISIS based on the service plan.

a. Services must be authorized and entered into ISIS before the plan implementation date.

b. The department has 15 working days after receipt of the summary and service costs in which to approve the services and service cost or request modification of the service plan unless the parties mutually agree to extend that time frame.

c. If the department and the service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department has final authority regarding the services and service cost.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.68(249A) Adverse service actions.

83.68(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The applicant is not eligible for the services.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. No HCBS intellectual disability waiver service is identified in the applicant's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the applicant that will meet the applicant's needs.

g. Completion or receipt of required documents by the department for the HCBS program applicant has not occurred.

83.68(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.68(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2) paragraph *"d,""g,"* or *"h,"*, apply.

b. Needed services are not available or received from qualifying providers.

c. No HCBS intellectual disability waiver service is identified in the member's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department for the HCBS program consumer has not occurred.

g. The consumer receives services from other Medicaid waiver programs.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

441—83.69(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.70(249A) County reimbursement. Rescinded **ARC 0191C**, IAB 7/11/12, effective 7/1/12.

441—83.71(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

441—83.72(249A) Rent subsidy program. Members in the HCBS intellectual disability waiver program may be eligible for a rent subsidy. See 265—Chapter 24.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11]

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.73 to **83.80** Reserved.

DIVISION V—BRAIN INJURY WAIVER SERVICES

441—83.81(249A) Definitions.

"Adaptive" means age appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication,

self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a brain injury aged 18 years or over.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Basic individual respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals without specialized needs requiring the care of a licensed registered nurse or licensed practical nurse.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Brain injury" means clinically evident damage to the brain resulting directly or indirectly from trauma, infection, anoxia, vascular lesions or tumor of the brain, not primarily related to degenerative or aging processes, which temporarily or permanently impairs a person's physical, cognitive, or behavioral functions. The person must have a diagnosis from the following list:

Malignant neoplasms of brain, cerebrum.

Malignant neoplasms of brain, frontal lobe.

Malignant neoplasms of brain, temporal lobe.

Malignant neoplasms of brain, parietal lobe.

Malignant neoplasms of brain, occipital lobe.

Malignant neoplasms of brain, ventricles.

Malignant neoplasms of brain, cerebellum.

Malignant neoplasms of brain, brain stem.

Malignant neoplasms of brain, other part of brain, includes midbrain, peduncle, and medulla oblongata.

Malignant neoplasms of brain, cerebral meninges.

Malignant neoplasms of brain, cranial nerves.

Secondary malignant neoplasm of brain.

Secondary malignant neoplasm of other parts of the nervous system, includes cerebral meninges.

Benign neoplasm of brain and other parts of the nervous system, brain.

Benign neoplasm of brain and other parts of the nervous system, cranial nerves.

Benign neoplasm of brain and other parts of the nervous system, cerebral meninges.

Encephalitis, myelitis and encephalomyelitis.

Intracranial and intraspinal abscess.

Anoxic brain damage.

Subarachnoid hemorrhage.

Intracerebral hemorrhage.

Other and unspecified intracranial hemorrhage.

Occlusion and stenosis of precerebral arteries.

Occlusion of cerebral arteries.

Transient cerebral ischemia.

Acute, but ill-defined, cerebrovascular disease.

Other and ill-defined cerebrovascular diseases.

Fracture of vault of skull.

Fracture of base of skull.

Other and unqualified skull fractures.

Multiple fractures involving skull or face with other bones.
Concussion.
Cerebral laceration and contusion.
Cerebral edema.
Cerebral palsy.
Subarachnoid, subdural, and extradural hemorrhage following injury.
Other and unspecified intracranial hemorrhage following injury.
Intracranial injury of other and unspecified nature.
Poisoning by drugs, medicinal and biological substances.
Toxic effects of substances.
Effects of external causes.
Drowning and nonfatal submersion.
Asphyxiation and strangulation.
Child maltreatment syndrome.
Adult maltreatment syndrome.
Status epilepticus.

"Case management services" means those services established pursuant to Iowa Code chapter 225C.

"Child" means a person with a brain injury aged 17 years or under.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of brain injury waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Deemed status" means acceptance of certification or licensure of a program or service by another certifying body in place of certification based on review and evaluation.

"Department" means the Iowa department of human services.

"Direct service" means services involving face-to-face assistance to a consumer such as transporting a consumer or providing therapy.

"Fiscal accountability" means the development and maintenance of budgets and independent fiscal review.

"Group respite" is respite provided on a staff-to-consumer ratio of less than one to one.

"Guardian" means a guardian appointed in probate court.

"Health" means skills related to the maintenance of one's health including eating; illness identification, treatment and prevention; basic first aid; physical fitness; regular physical checkups and personal habits.

"Immediate jeopardy" means circumstances where the life, health, or safety of a person will be severely jeopardized if the circumstances are not immediately corrected.

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

"Intermittent supported community living service" means supported community living service provided from one to three hours a day for not more than four days a week.

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

"Medical assessment" means a visual and physical inspection of the consumer, noting deviations from the norm, and a statement of the consumer's mental and physical condition that can be amendable to or resolved by appropriate actions of the provider.

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

"Medical intervention" means consumer care in the areas of hygiene, mental and physical comfort, assistance in feeding and elimination, and control of the consumer's care and treatment to meet the physical and mental needs of the consumer in compliance with the plan of care in areas of health, prevention, restoration, and maintenance.

"Medical monitoring" means observation for the purpose of assessing, preventing, maintaining, and treating disease or illness based on the consumer's plan of care.

"Natural supports" means services and supports identified as wanted or needed by the consumer and provider by persons not for pay (family, friends, neighbors, coworkers, and others in the community) and organizations or entities that serve the general public.

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

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

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

"Organization" means the entity being certified.

"Organizational outcome" means a demonstration by the organization of actions taken by the organization to provide for services or supports to consumers.

"Outcome" means an action or event that follows as a result or consequence of the provision of a service or support.

"Procedures" means the steps to be taken to implement a policy.

"Process" means service or support provided by an agency to a consumer that will allow the consumer to achieve an outcome. This can include a written, formal, consistent trackable method or an informal process that is not written but is trackable.

"Program" means a set of related resources and services directed to the accomplishment of a fixed set of goals and objectives for the population of a specified geographic area or for special target populations. It can mean an agency, organization, or unit of an agency, organization or institution.

"Qualified brain injury professional" means one of the following who meets the educational and licensure or certification requirements for the profession as required in the state of Iowa and who has two years' experience working with people living with a brain injury: a psychologist; psychiatrist; physician; physician assistant; registered nurse; certified teacher; social worker; mental health counselor; physical, occupational, recreational, or speech therapist; or a person with a bachelor of arts or science degree in psychology, sociology, or public health or rehabilitation services.

"Service coordination" means activities designed to help individuals and families locate, access, and coordinate a network of supports and services that will allow them to live a full life in the community.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process, which addresses all relevant services and supports being provided. It may involve more than one provider.

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

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

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

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

a. A physician order for all skilled services.

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

c. An individualized care plan that identifies support needs.

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

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

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

"Specialized respite" means respite provided on a staff-to-consumer ratio of one to one or higher to individuals with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.

"Staff" means a person under the direction of the organization to perform duties and responsibilities of the organization.

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Usual caregiver" means a person or persons who reside with the consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.82(249A) Eligibility. To be eligible for brain injury waiver services a consumer must meet eligibility criteria and be determined to need a service allowable under the program.

83.82(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a diagnosis of brain injury.

b. Be eligible for Medicaid under SSI, SSI-related, FMAP, or FMAP-related coverage groups or be eligible under the special income level (300 percent) coverage group consistent with a level of care in a medical institution.

c. Be at least one month of age.

d. Be a U.S. citizen and Iowa resident.

e. Rescinded IAB 7/11/01, effective 7/1/01.

f. Be determined by the IME medical services unit as in need of intermediate care facility for persons with an intellectual disability (ICF/ID), skilled nursing, or ICF level of care based on information submitted on a completed Form 470-4694 for children aged 3 and under, the interRAI - Pediatric Home Care (PEDS-HC) for those aged 4 to 20, or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. Form 470-4694, the interRAI - Pediatric Home Care (PEDS-HC), and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool for an individual are available to that individual from the individual's case manager or managed care organization.

g. Be assessed by the IME medical services unit as able to live in a home- or community-based setting where all medically necessary service needs can be met within the scope of this waiver.

h. At a minimum, receive a waiver service each quarter in addition to case management.

i. Choose HCBS.

j. To be eligible for interim medical monitoring and treatment services the consumer must be:

(1) Under the age of 21;

(2) Currently receiving home health agency services under rule 441—78.9(249A) and require medical assessment, medical monitoring, and regular medical intervention or intervention in a medical emergency during those services. (The home health aide services for which the consumer is eligible must be maximized before the consumer accesses interim medical monitoring and treatment.);

(3) Residing in the consumer's family home or foster family home; and

(4) In need of interim medical monitoring and treatment as ordered by a physician.

k. Receive services in a community, not an institutional, setting.

l. Be assigned a state payment slot within the yearly total approved by the Centers for Medicare and Medicaid Services.

m. For the consumer choices option as set forth in rule 441—subrule 78.43(15), not be living in a residential care facility.

n. For individual supported employment and long-term job coaching services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Not reside in a medical institution.

(4) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in this outcome.

o. For small-group supported employment services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive small-group supported employment services was made.

(5) Not reside in a medical institution.

p. For prevocational services:

(1) Be at least 16 years of age.

(2) The services must not be available to the member through one of the following:

1. Special education and related services as defined in the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.); or

2. A program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

(3) Have documented in the waiver service plan a goal to achieve or to sustain individual employment and an expectation that this service will result in community employment.

(4) Have documented in the waiver service plan that the choice to receive individual supported employment services was offered and explained in a manner sufficient to ensure informed choice, after which the choice to receive prevocational services was made.

83.82(2) *Need for services.*

a. The applicant shall have a service plan approved by the department that is developed by the certified case manager for this waiver as identified by the county of residence. This must be completed before services provision and annually thereafter. The case manager shall establish the interdisciplinary team for the applicant and, with the team, identify the applicant's need for service based on the applicant's needs and desires as well as the availability and appropriateness of services using the following criteria:

(1) The assessment shall be based, in part, on information provided to the IME medical services unit.

(2) Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid state services so as not to replace or duplicate those services.

(3) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent shall not be approved until a home health provider has made a request to cover the service through all nonwaiver Medicaid services.

(4) Service plans for applicants aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager must request in writing more than intermittent supported community living with a summary of services and service costs, and submit a written justification with the service plan. The rationale must contain sufficient information for the bureau's designee to make a decision regarding the need for supported community living beyond intermittent.

b. Interim medical monitoring and treatment services must be needed because all usual caregivers are unavailable to provide care due to one of the following circumstances:

(1) Employment. Interim medical monitoring and treatment services are to be received only during hours of employment.

(2) Academic or vocational training. Interim medical monitoring and treatment services provided while a usual caregiver participates in postsecondary education or vocational training shall be limited to 24 periods of no more than 30 days each per caregiver as documented by the service worker. Time spent in high school completion, adult basic education, GED, or English as a second language does not count toward the limit.

(3) Absence from the home due to hospitalization, treatment for physical or mental illness, or death of the usual caregiver. Interim medical monitoring and treatment services under this subparagraph are limited to a maximum of 30 days.

(4) Search for employment.

1. Care during job search shall be limited to only those hours the usual caregiver is actually looking for employment, including travel time.

2. Interim medical monitoring and treatment services may be provided under this paragraph only during the execution of one job search plan of up to 30 working days in a 12-month period, approved by the department service worker or targeted case manager pursuant to 441—subparagraph 170.2(2)*"b"*(5).

3. Documentation of job search contacts shall be furnished to the department service worker or targeted case manager.

c. The consumer shall access, if a child, all other services for which the person is eligible and which are appropriate to meet the person's needs as a precondition of eligibility for the HCBS BI waiver.

d. The total cost of brain injury waiver services, excluding the cost of case management and home and vehicle modifications, shall not exceed $3,013.08 per month.

83.82(3) *HCBS brain injury (BI) waiver program limit for persons requiring the ICF/MR level of care.* Rescinded IAB 7/11/01, effective 7/1/01.

83.82(4) *Securing a state payment slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a payment slot is available for all new applicants for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no payment slot is available, the department shall enter the applicant on a waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added to the waiting list on the basis of the date the applicant requests HCBS BI program services.

(2) 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 month of birth, January being month one and the lowest number.

c. Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2471C**, IAB 3/30/16, effective 5/4/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.83(249A) Application.

83.83(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed.

83.83(2) *Approval of application for eligibility.*

a. Applications for the determination of ability of the consumer to have all medically necessary service needs met within the scope of this waiver shall be initiated on behalf of the consumer and with the consumer's consent or with the consent of the consumer's legal representative by the discharge planner of the medical facility where the consumer resides at the time of application or the case manager. The discharge planner or case manager shall provide to the IME medical services unit all appropriate information needed regarding all the medically necessary service needs of the consumer. After completing the determination of ability to have all medically necessary service needs met within the scope of this waiver, the IME medical services unit shall inform the discharge planner or case manager on behalf of the consumer or the consumer's legal representative and send to the income maintenance worker a copy of the decision as to whether all of the consumer's service needs can be met in a home- or community-based setting.

b. Eligibility for the HCBS BI waiver shall be effective as of the date when both the service eligibility and financial eligibility have been completed. Decisions shall be mailed or given to the consumer or the consumer's legal representative on the date when each eligibility determination is completed.

c. An applicant shall be given the choice between waiver services and institutional care. The applicant or legal representative shall sign the applicable information submission tool listed in paragraph 83.82(1)*"f,"* indicating that the applicant has elected home- and community-based services. This shall be arranged by the medical facility discharge planner or case manager.

d. The medical facility discharge planner, if there is one involved, shall contact the consumer's managed care organization or the designated case manager to initiate development of the consumer's service plan and initiation of waiver services.

e. HCBS BI waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

f. HCBS BI waiver services are not available in conjunction with other HCBS waiver programs or group foster care services.

g. The Medicaid case manager shall establish an HCBS BI waiver interdisciplinary team for each consumer and, with the team, identify the consumer's "need for service" based on the consumer's needs and desires as well as the availability and appropriateness of services.

83.83(3) *Effective date of eligibility.*

a. The effective date of eligibility for the waiver for persons who are already determined eligible for Medicaid is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A).

b. The effective date of eligibility for the waiver for persons who qualify for Medicaid due to eligibility for the waiver services is the date on which the person is determined to meet all of the criteria set forth in rule 441—83.82(249A) and when the eligibility factors set forth in 441—subrule 75.1(7) and for married persons, in rule 441—75.5(249A), have been satisfied.

c. Eligibility for the waiver continues until the consumer fails to meet eligibility criteria listed in rule 441—83.82(249A). Consumers who return to inpatient status in a medical institution for more than 30 consecutive days shall be reviewed by the IME medical services unit to determine additional inpatient needs for possible termination from the brain injury waiver. The consumer shall be reviewed for eligibility under other Medicaid coverage groups in accordance with rule 441—76.11(249A). The consumer shall be notified of that decision through Form 470-0602, Notice of Decision.

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

83.83(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the level of care criteria in a medical institution as established by the peer review organization shall be used as the date of entry to the medical

institution. Only one attribution of resources shall be completed per person. Attributions completed for prior institutionalizations shall be applied to the waiver application.
[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.84(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a predetermined participation amount to the cost of brain injury waiver services.

83.84(1) *Computation of client participation.* Client participation shall be computed by deducting an amount for the maintenance needs of the consumer which is 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.84(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific brain injury waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.85(249A) Redetermination. A complete financial redetermination of eligibility for brain injury waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.82(249A). A redetermination shall contain the components listed in rule 441—83.82(249A).

441—83.86(249A) Allowable services. Services allowable under the brain injury waiver are case management, respite, personal emergency response, supported community living, behavioral programming, family counseling and training, home and vehicle modification, specialized medical equipment, prevocational services, transportation, supported employment, adult day care, consumer-directed attendant care, interim medical monitoring and treatment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.43(249A).

441—83.87(249A) Service plan. A service plan shall be prepared and utilized for each HCBS BI waiver consumer. The service plan shall be developed by an interdisciplinary team, which includes the consumer, and, if appropriate, the legal representative, consumer's family, case manager, providers, and others directly involved. The service plan shall be stored by the case manager for a minimum of three years. The service plan staffing shall be conducted before the current service plan expires.

83.87(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. For supported community living:

(1) The consumer's living environment at the time of waiver enrollment.

(2) The number of hours per day of on-site staff supervision needed by the consumer.

(3) The number of other waiver consumers who will live with the consumer in the living unit.

c. An identification and justification of any restriction of a consumer's rights including, but not limited to:

(1) Maintenance of personal funds.

(2) Self-administration of medications.

d. The names of all providers responsible for providing all services.

e. All service funding sources.

f. The amount of the service to be received by the consumer.

g. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

h. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.87(2) *Use of nonwaiver services.* Service plans must be developed to reflect use of all appropriate nonwaiver Medicaid services and so as not to replace or duplicate those services. Service plans for members aged 20 or under which include supported community living services beyond intermittent must be approved (signed and dated) by the designee of the bureau of long-term care. The Medicaid case manager shall attach a written request for a variance from the limitation on supported community living to intermittent.

83.87(3) *Annual assessment.* The IME medical services unit shall assess the member annually and certify the member's need for long-term care services. The IME medical services unit shall be responsible for determining the level of care based on the completed information submission tool listed in paragraph 83.82(1)*"f"* and other supporting documentation as relevant.

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

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

83.87(4) *Service file.* The Medicaid case manager must ensure that the consumer service file contains the consumer's service plan.

a. to *d.* Rescinded IAB 8/7/02, effective 10/1/02.

[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.88(249A) Adverse service actions.

83.88(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. The consumer is not eligible for the services because all of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the service unit or reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The brain injury waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

83.88(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.88(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The brain injury waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the department or the medical facility discharge planner for the brain injury waiver service consumer has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative through the interdisciplinary process requests termination from the services.

441—83.89(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).
[**ARC 0191C**, IAB 7/11/12, effective 7/1/12; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0359C**, IAB 10/3/12, effective 12/1/12]

441—83.90(249A) County reimbursement. Rescinded **ARC 0191C**, IAB 7/11/12, effective 7/1/12.

441—83.91(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.92 to **83.100** Reserved.

DIVISION VI—PHYSICAL DISABILITY WAIVER SERVICES

441—83.101(249A) Definitions.

"Adaptive" means age-appropriate skills related to taking care of one's self and the ability to relate to others in daily living situations. These skills include limitations that occur in the areas of communication, self-care, home living, social skills, community use, self-direction, safety, functional academics, leisure and work.

"Adult" means a person with a physical disability aged 18 years to 64 years.

"Appropriate" means that the services or supports or activities provided or undertaken by the organization are relevant to the consumer's needs, situation, problems, or desires.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, strengths, abilities, desires and goals.

"Attorney in fact under a durable power of attorney for health care" means an individual who is designated by a durable power of attorney for health care, pursuant to Iowa Code chapter 144B, as an agent to make health care decisions on behalf of an individual and who has consented to act in that capacity.

"Behavior" means skills related to regulating one's own behavior including coping with demands from others, making choices, controlling impulses, conforming conduct to laws, and displaying appropriate sociosexual behavior.

"Client participation" means the amount of the consumer's income that the person must contribute to the cost of physical disability waiver services, exclusive of medical vendor payments, before Medicaid will provide additional reimbursement.

"Department" means the Iowa department of human services.

"Guardian" means a guardian appointed in probate court for an adult.

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

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

"Medical institution" means a nursing facility, a skilled nursing facility, intermediate care facility for persons with an intellectual disability, or hospital which has been approved as a Medicaid vendor.

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

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

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

"Physical disability" means a severe, chronic condition that is attributable to a physical impairment that results in substantial limitations of physical functioning in three or more of the following areas of major life activities: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

"Service plan" means a written consumer-centered, outcome-based plan of services developed using an interdisciplinary process which addresses all relevant services and supports being provided. It may involve more than one provider.

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

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

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

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

a. A physician order for all skilled services.

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

c. An individualized care plan that identifies support needs.

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

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

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

"Third-party payments" means payments from an individual, institution, corporation, or public or private provider which is liable to pay part or all of the medical costs incurred as a result of injury or disease on behalf of a consumer of medical assistance.

"Waiver year" means a 12-month period commencing on April 1 of each year.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16]

441—83.102(249A) Eligibility. To be eligible for physical disability waiver services, a consumer must meet eligibility criteria set forth in subrule 83.102(1) and be determined to need a service allowable under the program per subrule 83.102(2).

83.102(1) *Eligibility criteria.* All of the following criteria must be met. The person must:

a. Have a physical disability.

b. Be blind or disabled as determined by the receipt of social security disability benefits or by a disability determination made through the department. Disability determinations are made according to supplemental security income guidelines under Title XVI of the Social Security Act or the disability guidelines for the Medicaid employed people with disabilities coverage group.

c. Be ineligible for the HCBS intellectual disability waiver.

d. Have the ability to hire, supervise, and fire the provider as determined by the service worker, and be willing to do so, or have a parent or guardian named by probate court, or attorney in fact under a durable power of attorney for health care who will take this responsibility on behalf of the consumer.

e. Be eligible for Medicaid under 441—Chapter 75.

f. Be aged 18 years to 64 years.

g. Rescinded IAB 2/7/01, effective 2/1/01.

h. Be in need of skilled nursing or intermediate care facility level of care based on information submitted on a completed interRAI - Pediatric Home Care (PEDS-HC) for those aged 18 to 20 or the interRAI - Home Care (HC) for those aged 21 and over and other supporting documentation as relevant. The interRAI - Pediatric Home Care (PEDS-HC) and the interRAI - Home Care (HC) are available on request from the IME medical services unit. Copies of the completed information submission tool

for an individual are available to that individual from the individual's case manager or managed care organization.

(1) Initial decisions on level of care shall be made for the department by the IME medical services unit within two working days of receipt of medical information. The IME medical services unit determines whether the level of care requirement is met based on medical necessity and the appropriateness of the level of care under 441—subrules 79.9(1) and 79.9(2).

(2) Adverse decisions by the IME medical services unit may be appealed to the department pursuant to 441—Chapter 7.

i. Choose HCBS.

j. Use a minimum of one unit of service per calendar quarter under this program.

k. For the consumer choices option as set forth in 441—subrule 78.46(6), not be living in a residential care facility.

83.102(2) *Need for services.*

a. The applicant shall have a service plan which is developed by the applicant and a department service worker. The plan must be completed and approved before service provision.

(1) The designated case manager shall identify the need for service based on the needs of the applicant, as documented in the information submission tool listed in 83.102(1)*"h,"* as well as the availability and appropriateness of services.

(2) The service worker shall have a face-to-face visit with the member at least annually.

b. The total cost of physical disability waiver services, excluding the cost of home and vehicle modifications, shall not exceed $705.84 per month.

83.102(3) *Slots.* The total number of persons receiving HCBS physical disability waiver services in the state shall be limited to the number provided in the waiver approved by the Secretary of the U.S. Department of Health and Human Services. These slots shall be available on a first-come, first-served basis.

83.102(4) *County payment slots for persons requiring the ICF/MR level of care.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(5) *Securing a slot.*

a. The county department office shall enter all waiver applications into the individualized services information system (ISIS) to determine if a slot is available for all new applicants for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall make the entry by the end of the fifth working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, or within five working days after receipt of disability determination, whichever is later.

(2) For current Medicaid members, the county department office shall make the entry by the end of the fifth working day after receipt of a written request signed and dated by the waiver applicant.

b. If no slot is available, the department shall enter applicants on the HCBS physical disabilities waiver waiting list according to the following:

(1) Applicants not currently eligible for Medicaid shall be entered on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department or upon receipt of disability determination, whichever is later. Applicants currently eligible for Medicaid shall be added on the basis of the date the applicant requests HCBS physical disability program services. In the event that more than one application is received on the same day, applicants shall be entered on the waiting list on the basis of the day of the month of their birthday, the lowest number being first on the list. Any subsequent tie shall be decided by the month of birth, January being month one and the lowest number.

(2) Persons who do not fall within the available slots shall have their applications rejected but their names shall be maintained on the waiting list. As slots become available, persons shall be selected from the waiting list to maintain the number of approved persons on the program based on their order on the waiting list.

83.102(6) *Securing a county payment slot.* Rescinded IAB 10/6/99, effective 10/1/99.

83.102(7) *HCBS physical disability waiver waiting list.* When services are denied because the limit on the number of slots is reached, a notice of decision denying service based on the limit and stating that the person's name shall be put on a waiting list shall be sent to the person by the department.

[**ARC 9650B**, IAB 8/10/11, effective 10/1/11; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.103(249A) Application.

83.103(1) *Application for financial eligibility.* The application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed. Applications for this program may only be filed on or after April 1, 1999.

83.103(2) *Approval of application for eligibility.*

a. Applications for this waiver shall be initiated on behalf of the applicant who is a resident of a medical institution with the applicant's consent or with the consent of the applicant's legal representative by the discharge planner of the medical facility where the applicant resides at the time of application.

(1) The discharge planner shall contact the member's managed care organization or designated case manager to arrange for completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h."*

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the discharge planner of the IME medical services unit's decision.

b. Applications for this waiver shall be initiated by the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on behalf of the applicant who is residing in the community.

(1) The applicant's managed care organization or the designated case manager shall arrange for the completion of the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and submit it to the IME medical services unit.

(2) After completing the determination of the level of care needed by the applicant, the IME medical services unit shall inform the income maintenance worker and the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care.

c. Eligibility for this waiver shall be effective as of the date when both the eligibility criteria in subrule 83.102(1) and need for services in subrule 83.102(2) have been established. Decisions shall be mailed or given to the applicant, the applicant's parent or legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care on the date when each eligibility determination is completed.

d. An applicant shall be given the choice between waiver services and institutional care. The applicant or the applicant's parent, legal guardian, or attorney in fact under a durable power of attorney for health care shall sign the information submission tool, indicating that the applicant has elected home- and community-based services.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the designated case manager in the development of the service plan prior to the start of services.

f. HCBS physical disability waiver services provided prior to both approvals of eligibility for the waiver cannot be paid.

g. HCBS physical disability waiver services are not available in conjunction with other HCBS waiver programs. The consumer may also receive in-home health-related care service if eligible for that program.

83.103(3) *Effective date of eligibility.*

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

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

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

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

83.103(4) *Attribution of resources.* For the purposes of attributing resources as provided in rule 441—75.5(249A), the date on which the waiver consumer meets the institutional level of care requirement as determined by the IME medical services unit or an appeal decision shall be used as the date of entry to the medical institution. Only one attribution of resources shall be completed per person. Attributions completed for a prior institutionalization shall be applied to the waiver application.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.104(249A) Client participation. Consumers who are financially eligible under 441—subrule 75.1(7) (the 300 percent group) must contribute a client participation amount to the cost of physical disability waiver services.

83.104(1) *Computation of client participation.* Client participation shall be computed by deducting a maintenance needs allowance equal to 300 percent of the maximum SSI grant for an individual from the consumer's total income. For a couple, client participation is determined as if each person were an individual.

83.104(2) *Limitation on payment.* If the sum of the third-party payment and client participation equals or exceeds the reimbursement for the specific physical disability waiver service, Medicaid shall make no payments for the waiver service. However, Medicaid shall make payments to other medical providers.

441—83.105(249A) Redetermination. A complete financial redetermination of eligibility for the physical disability waiver shall be completed at least once every 12 months. A redetermination of continuing eligibility factors shall be made when a change in circumstances occurs that affects eligibility in accordance with rule 441—83.102(249A). A redetermination shall contain the components listed in rule 441—83.102(249A).

441—83.106(249A) Allowable services. The services allowable under the physical disability waiver are consumer-directed attendant care, home and vehicle modification, personal emergency response system, transportation, specialized medical equipment, financial management, independent support brokerage, self-directed personal care, self-directed community supports and employment, and individual-directed goods and services as set forth in rule 441—78.46(249A).

441—83.107(249A) Individual service plan. An individualized service plan shall be prepared and used for each HCBS physical disability waiver consumer. The service plan shall be developed and approved by the consumer, the consumer's interdisciplinary team and the designated case manager prior to services beginning and payment being made to the provider.

83.107(1) *Information in plan.* The plan shall be in accordance with 441—subrule 24.4(3) and shall additionally include the following information to assist in evaluating the program:

a. A listing of all services received by a consumer at the time of waiver program enrollment.

b. The name of all providers responsible for providing all services.

c. All service funding sources.

d. The amount of the service to be received by the consumer.

e. Whether the consumer has elected the consumer choices option and, if so:

(1) The independent support broker selected by the consumer; and

(2) The financial management service selected by the consumer.

f. A plan for emergencies and identification of the supports available to the consumer in an emergency.

83.107(2) *Annual assessment.* The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to paragraph 83.102(1)*"h"* and the appeal process at rule 441—83.109(249A), based on the appropriate information submission tool as listed in paragraph 83.102(1)*"h"* and other supporting documentation as relevant.

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

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

83.107(3) *Case file.* Rescinded IAB 8/7/02, effective 10/1/02.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.108(249A) Adverse service actions.

83.108(1) *Denial.* An application for services shall be denied when it is determined by the department that:

a. All of the medically necessary service needs cannot be met in a home- or community-based setting.

b. Service needs exceed the reimbursement maximums.

c. Service needs are not met by the services provided.

d. Needed services are not available or received from qualifying providers.

e. The physical disability waiver service is not identified in the consumer's service plan.

f. There is another community resource available to provide the service or a similar service free of charge to the consumer that will meet the consumer's needs.

g. The consumer receives services from other Medicaid waiver providers.

h. The consumer or legal representative requests termination from the services.

83.108(2) *Reduction.* A particular service may be reduced when the department determines that the provisions of 441—subrule 130.5(3), paragraph *"a"* or *"b,"* apply.

83.108(3) *Termination.* A particular service may be terminated when the department determines that:

a. The provisions of 441—subrule 130.5(2), paragraph *"d," "g,"* or *"h,"* apply.

b. Needed services are not available or received from qualifying providers.

c. The physical disability waiver service is not identified in the consumer's annual service plan.

d. Service needs are not met by the services provided.

e. Services needed exceed the service unit or reimbursement maximums.

f. Completion or receipt of required documents by the consumer for the physical disability waiver service has not occurred.

g. The consumer receives services from other Medicaid providers.

h. The consumer or legal representative requests termination from the services.

441—83.109(249A) Appeal rights. Notice of adverse actions and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

83.109(1) *Appeal to county.* Rescinded IAB 2/7/01, effective 2/1/01.

83.109(2) *Reconsideration request to IME medical services unit.* Rescinded IAB 9/5/12, effective 11/1/12.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

441—83.110(249A) County reimbursement. Rescinded IAB 10/6/99, effective 10/1/99.

441—83.111(249A) Conversion to the X-PERT system. Rescinded IAB 8/7/02, effective 10/1/02.

These rules are intended to implement Iowa Code sections 249A.3 and 249A.4.

441—83.112 to **83.120** Reserved.

DIVISION VII—HCBS CHILDREN'S MENTAL HEALTH WAIVER SERVICES

441—83.121(249A) Definitions.

"Assessment" means the review of the consumer's current functioning in regard to the consumer's situation, needs, abilities, desires, and goals.

"Care coordinator" means the professional who assists members in care coordination as described in 441—paragraph 78.53(1)*"b."*

"Case manager" means the person designated to provide Medicaid targeted case management services for the consumer.

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

"Consumer" means an individual up to the age of 18 who is included in a Medicaid coverage group listed in 441—75.1(249A) and is a recipient of children's mental health waiver services.

"Deeming" means considering parental or spousal income or resources as income or resources of a consumer in determining eligibility for a consumer according to Supplemental Security Income program guidelines.

"Department" means the Iowa department of human services.

"Guardian" means a parent of a consumer or a legal guardian appointed by the court.

"HCBS" means home- and community-based services provided under a Medicaid waiver.

"IME" means the Iowa Medicaid enterprise.

"IME medical services unit" means the contracted entity in the Iowa Medicaid enterprise that determines level of care for consumers initially applying for or continuing to receive children's mental health waiver services.

"Integrated health home" means the provision of services to enrolled members as described in 441—subrule 78.53(1).

"Interdisciplinary team" means the consumer, the consumer's family, and persons of varied professional and nonprofessional backgrounds with knowledge of the consumer's needs, as designated by the consumer and the consumer's family, who meet to develop a service plan based on the individualized needs of the consumer.

"ISIS" means the department's individualized services information system.

"Local office" means a department of human services office as described in 441—subrule 1.4(2).

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

"Medical institution" means a nursing facility, an intermediate care facility for persons with an intellectual disability, a psychiatric hospital or psychiatric medical institution for children, or a state mental health institute that has been approved as a Medicaid vendor.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

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

"Serious emotional disturbance" means a diagnosable mental, behavioral, or emotional disorder that (1) is of sufficient duration to meet diagnostic criteria for the disorder specified by the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association; and (2) has resulted in a functional impairment that substantially interferes with or limits a consumer's role or functioning in family, school, or community activities. "Serious emotional disturbance" shall not include neurodevelopmental disorders, substance-related disorders, or conditions or problems classified in the current version of the DSM as "other conditions that may be a focus of clinical attention," unless these conditions co-occur with another diagnosable serious emotional disturbance.

"Service plan" means a written, consumer-centered, outcome-based plan of services developed by the consumer's interdisciplinary team that addresses all relevant services and supports being provided. The service plan may involve more than one provider.

"Skill development" means that the service provided is habilitative and is intended to impart an ability or capacity to the consumer. Supervision without habilitation is not skill development.

"Targeted case management" means Medicaid case management services accredited under 441—Chapter 24 and provided according to 441—Chapter 90 for consumers eligible for the children's mental health waiver.

"Waiver year" for the children's mental health waiver means a 12-month period commencing on July 1 of each year.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2164C**, IAB 9/30/15, effective 10/1/15; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.122(249A) Eligibility. To be eligible for children's mental health waiver services, a consumer must meet all of the following requirements:

83.122(1) *Age.* The consumer must be under 18 years of age.

83.122(2) *Diagnosis.* The consumer must be diagnosed with a serious emotional disturbance.

a. Initial certification. For initial application to the HCBS children's mental health waiver program, psychological documentation that substantiates a mental health diagnosis of serious emotional disturbance as determined by a mental health professional must be current within the 12-month period before the application date.

b. Ongoing certification. A mental health professional must complete an annual evaluation that substantiates a mental health diagnosis of serious emotional disturbance.

83.122(3) *Level of care.* The applicant must be certified as being in need of a level of care that, but for the waiver, would be provided in a psychiatric hospital serving children under the age of 21. The IME medical services unit or a managed care organization shall certify the applicant's level of care annually based on information submitted on Form 470-4694, Case Management Comprehensive Assessment, for children aged 3 and under or on the interRAI - Child and Youth Mental Health (ChYMH) for those aged 4 to 20 and other supporting documentation as relevant. For those aged 12 to 18, the interRAI - Adolescent Supplement shall also be completed in addition to the interRAI - Child and Youth Mental Health (ChYMH). Form 470-4694, the interRAI - Child and Youth Mental Health (ChYMH), and the interRAI - Adolescent Supplement are available on request from the IME medical services unit. Copies

of the completed information submission tool for an individual are available to that individual from the individual's case manager, integrated health home care coordinator or managed care organization.

83.122(4) *Financial eligibility.* The consumer must be eligible for Medicaid as follows:

a. Be eligible for Medicaid under an SSI, SSI-related, FMAP, or FMAP-related coverage group; or

b. Be eligible under the special income level (300 percent) coverage group; or

c. Become eligible through application of the institutional deeming rules; or

d. Would be eligible for Medicaid if in a medical institution. For this purpose, deeming of parental or spousal income or resources ceases in the month after the month of application.

83.122(5) *Choice of program.* The applicant must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the applicant's parent or legal guardian on the assessment.

83.122(6) *Need for service.* The consumer must have service needs that can be met under the children's mental health waiver program, as documented in the service plan developed in accordance with rule 441—83.12(249A).

a. The consumer must be a recipient of case management or integrated health home services or be identified to receive case management or integrated health home services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the member's needs, excluding the cost of environmental modifications, adaptive devices and therapeutic resources, may not exceed $2,006.34 per month.

c. At a minimum, each consumer must receive one billable unit of a children's mental health waiver service per calendar quarter.

d. A consumer may not receive children's mental health waiver services and foster family care services under 441—Chapter 202 at the same time.

e. A consumer may be enrolled in only one HCBS waiver program at a time.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 0548C**, IAB 1/9/13, effective 1/1/13; **ARC 0665C**, IAB 4/3/13, effective 6/1/13; **ARC 0842C**, IAB 7/24/13, effective 7/1/13; **ARC 1056C**, IAB 10/2/13, effective 11/6/13; **ARC 1445C**, IAB 4/30/14, effective 7/1/14; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 2848C**, IAB 12/7/16, effective 11/15/16; **ARC 2936C**, IAB 2/1/17, effective 3/8/17; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.123(249A) Application. The Medicaid application process as specified in rules 441—76.1(249A) to 441—76.6(249A) shall be followed for an application for HCBS children's mental health waiver services.

83.123(1) *Program limit.* The number of persons who may be approved for the HCBS children's mental health waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS children's mental health waiver. When the number of applicants exceeds the number of consumers specified in the approved waiver, the consumer's application shall be rejected and the consumer's name shall be placed on a waiting list.

a. The local office shall determine if a payment slot is available by the end of the fifth working day after receipt of:

(1) A completed Form 470-2297, Health Services Application, from a consumer who is not currently a Medicaid member; or

(2) A written request signed and dated by a Medicaid member's parent or legal guardian.

b. When a payment slot is available, the local office shall enter the application into ISIS to begin the waiver approval process.

(1) The department shall hold the payment slot for the consumer as long as reasonable efforts are being made to arrange services and the consumer has not been determined to be ineligible for the program.

(2) If services have not been initiated and reasonable efforts are no longer being made to arrange services, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer must reapply for a new slot.

c. If no payment slot is available, the department shall enter the names of persons on a waiting list according to the following:

(1) The names of applicants not currently eligible for Medicaid shall be entered on the waiting list on the basis of the date a completed Form 470-2927 or 470-2927(S), Health Services Application, is received by the department;

(2) The names of Medicaid members shall be added to the waiting list on the date as specified in paragraph 83.123(1)*"a."*

(3) In the event that more than one application is received at one time, the names of consumers shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

d. Consumers whose names are on the waiting list shall be contacted to reapply as slots become available, based on the order of the waiting list, so that the number of approved consumers on the program is maintained.

(1) Once a payment slot is assigned, the department shall give written notice to the consumer within five working days.

(2) The department shall hold the payment slot for 30 days for the consumer to file a new application.

(3) If an application has not been filed within 30 days, the slot shall revert for use by the next consumer on the waiting list, if applicable. The consumer originally assigned the slot must reapply for a new slot.

83.123(2) *Approval of waiver eligibility.*

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

(1) An application has been filed and is pending for federal Supplemental Security Income (SSI) benefits.

(2) The application is pending because the department has not received information for a reason that is beyond the control of the consumer or the department.

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

b. *Notice of decisions.* The department shall mail or give decisions to the applicant on the dates when eligibility and level of care determinations are completed.

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

a. All eligibility requirements are met; and

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

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.124(249A) Financial participation. A consumer must contribute to the cost of children's mental health waiver services to the extent of the consumer's total income less 300 percent of the maximum monthly payment for one person under the federal Supplemental Security Income (SSI) program.

441—83.125(249A) Redetermination. The department shall redetermine a consumer's eligibility for the children's mental health waiver at least once every 12 months or when there is significant change in the consumer's situation or condition.

83.125(1) *Eligibility review.*

a. Every 12 months, the department shall review a consumer's eligibility in accordance with procedures in rule 441—76.7(249A). The review shall verify continuing eligibility factors as specified in rule 441—83.122(249A).

b. The IME medical services unit or a managed care organization shall review the member's need for continued care annually and recertify the member's need for long-term care services, pursuant to rule 441—83.122(249A) and the appeal process at rule 441—83.129(249A), based on the completed information submission tool designated in 83.122(3) and other supporting documentation as relevant.

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

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

83.125(2) *Continuation of eligibility.* A consumer's waiver eligibility shall continue until one of the following conditions occurs.

a. The consumer fails to meet eligibility criteria listed in rule 441—83.122(249A).

b. The consumer is an inpatient of a medical institution for 30 or more consecutive days.

(1) After the consumer has spent 30 consecutive days in a medical institution, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

(2) If the consumer returns home after 30 consecutive days but no more than 60 days, the consumer must reapply for children's mental health waiver services, and the IME medical services unit must redetermine the consumer's level of care.

c. The consumer does not reside at the consumer's natural home for a period of 60 consecutive days. After the consumer has resided outside the home for 60 consecutive days, the local office shall terminate the consumer's waiver eligibility and review the consumer for eligibility under other Medicaid coverage groups. The local office shall notify the consumer and the consumer's parents or legal guardian through Form 470-0602, Notice of Decision.

83.125(3) *Payment slot.* When a consumer loses waiver eligibility, the consumer's assigned payment slot shall revert for use to the next consumer on the waiting list.

[**ARC 2361C**, IAB 1/6/16, effective 1/1/16; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.126(249A) Allowable services. Services allowable under the children's mental health waiver shall be provided as set forth in rule 441—78.52(249A) and shall include:

1. Environmental modifications, adaptive devices and therapeutic resources;
2. Family and community support services;
3. In-home family therapy; and
4. Respite care.

441—83.127(249A) Service plan. The consumer's case manager or integrated health home care coordinator shall prepare an individualized service plan for each consumer that meets the requirements set for case plans in rule 441—130.7(234).

83.127(1) The service plan shall be developed through an interdisciplinary team process.

83.127(2) The service plan shall be developed annually or when there is significant change in the consumer's situation or condition.

83.127(3) The service plan shall be based on information in the completed information submission tool designated in subrule 83.122(3) and other supporting documentation as relevant.

83.127(4) The service plan shall specify the type and frequency of the waiver services and the providers that will deliver the services.

83.127(5) The service plan shall identify and justify any restriction of the consumer's rights.

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12; **ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.128(249A) Adverse service actions.

83.128(1) *Denial.* An application for children's mental health waiver services shall be denied when the department determines that:

a. The consumer is not eligible for or in need of waiver services.

b. Needed services are not available or received from qualified providers.

c. Service needs exceed the limit on aggregate monthly costs established in 83.122(6)*"c"* or are not met by the services provided.

83.128(2) *Termination.* A consumer's participation in the children's mental health waiver program may be terminated when the department determines that:

a. The provisions of 441—paragraph 130.5(2)*"a," "b," "c," "g,"* or *"h"* apply.

b. The costs of the children's mental health waiver services for the consumer exceed the aggregate monthly costs established in 83.122(6)*"c."*

c. The consumer receives care in a hospital, nursing facility, psychiatric hospital serving children under the age of 21, or psychiatric medical institution for children for 30 days in any one stay.

d. The physical or mental condition of the consumer requires more care than can be provided in the consumer's own home, as determined by the consumer's case manager or integrated health home care coordinator.

e. Service providers are not available.

83.128(3) *Reduction.* Reduction of services shall apply as specified in 441—paragraphs 130.5(3)*"a"* and *"b."*

[**ARC 3184C**, IAB 7/5/17, effective 8/9/17]

441—83.129(249A) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7 and rule 441—130.5(234).

[**ARC 0306C**, IAB 9/5/12, effective 11/1/12]

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed 1/22/86, Notice 12/4/85—published 2/12/86, effective 4/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 5/13/88 after Notice 3/23/88—published 6/1/88, effective 6/1/88]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 3/16/90, Notice 2/7/90—published 4/4/90, effective 6/1/90]
[Filed 4/13/90, Notice 11/29/89—published 5/2/90, effective 8/1/90]
[Filed emergency 6/13/90—published 7/11/90, effective 6/14/90]
[Filed 10/12/90, Notice 8/8/90—published 10/31/90, effective 2/1/91]
[Filed 1/17/91, Notices 11/14/90, 11/28/90—published 2/6/91, effective 4/1/91]
[Filed emergency 5/17/91 after Notice of 4/3/91—published 6/12/91, effective 7/1/91]
[Filed 10/10/91, Notice 9/4/91—published 10/30/91, effective 1/1/92]
[Filed emergency 1/16/92, Notice 11/27/91—published 2/5/92, effective 3/1/92]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 7/17/92, Notice 5/13/92—published 8/5/92, effective 10/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 9/11/92, Notice 7/8/92—published 9/30/92, effective 12/1/92]
[Filed emergency 7/13/93 after Notice 5/12/93—published 8/4/93, effective 8/1/93]
[Filed 8/12/93, Notice 4/28/93—published 9/1/93 effective 11/1/93]
[Filed 10/14/93, Notice 8/18/93—published 11/10/93, effective 1/1/94]
[Filed emergency 12/16/93 after Notice 10/27/93—published 1/5/94, effective 1/1/94]
[Filed emergency 2/10/94 after Notice 1/5/94—published 3/2/94, effective 3/1/94]
[Filed emergency 7/15/94 after Notice 6/8/94—published 8/3/94, effective 8/1/94]
[Filed 11/9/94, Notice 9/14/94—published 12/7/94, effective 2/1/95]
[Filed 12/15/94, Notice 11/9/94—published 1/4/95, effective 3/1/95]
[Filed 2/16/95, Notice 11/23/94—published 3/15/95, effective 5/1/95]
[Filed 5/11/95, Notice 3/29/95—published 6/7/95, effective 8/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]

[Filed 11/16/95, Notices 8/2/95, 9/13/95, 9/27/95—published 12/6/95, effective 2/1/96]
[Filed 5/15/96, Notice 2/14/96—published 6/5/96, effective 8/1/96]
[Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
[Filed 7/10/96, Notice 4/24/96—published 7/31/96, effective 10/1/96]
[Filed 8/15/96, Notice 6/19/96—published 9/11/96, effective 11/1/96]
[Filed emergency 10/9/96 after Notice 8/14/96—published 11/6/96, effective 11/1/96]
[Filed 1/15/97, Notice 11/20/96—published 2/12/97, effective 4/1/97]
[Filed 3/12/97, Notices 1/1/97, 1/29/97—published 4/9/97, effective 6/1/97]
[Filed emergency 5/14/97 after Notice 3/12/97—published 6/4/97, effective 7/1/97]
[Filed 6/12/97, Notice 4/23/97—published 7/2/97, effective 10/1/97]
[Filed 11/12/97, Notice 9/10/97—published 12/3/97, effective 2/1/98]
[Filed 12/10/97, Notice 11/5/97—published 12/31/97, effective 4/1/98]
[Filed 4/8/98, Notice 2/11/98—published 5/6/98, effective 7/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed 6/10/98, Notice 5/6/98—published 7/1/98, effective 10/1/98]
[Filed 8/12/98, Notices 6/17/98, 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 12/9/98, Notice 10/7/98—published 12/30/98, effective 4/1/99]
[Filed 1/13/99, Notice 11/4/98—published 2/10/99, effective 4/1/99]
[Filed 2/10/99, Notice 12/16/98—published 3/10/99, effective 5/1/99]
[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 8/11/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed emergency 9/13/99—published 10/6/99, effective 10/1/99]
[Filed 11/10/99, Notice 10/6/99—published 12/1/99, effective 2/1/00]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 9/12/00, Notice 6/14/00—published 10/4/00, effective 12/1/00]
[Filed emergency 1/10/01 after Notice 11/29/00—published 2/7/01, effective 2/1/01]
[Filed 2/14/01, Notice 12/13/00—published 3/7/01, effective 5/1/01]
[Filed emergency 6/13/01 after Notice 4/18/01—published 7/11/01, effective 7/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
[Filed 7/15/02, Notice 5/1/02—published 8/7/02, effective 10/1/02]
[Filed 10/10/02, Notice 8/21/02—published 10/30/02, effective 1/1/03]
[Filed emergency 6/12/03 after Notice 4/30/03—published 7/9/03, effective 6/15/03]
[Filed emergency 6/12/03—published 7/9/03, effective 7/1/03]
[Filed 9/22/03, Notice 7/9/03—published 10/15/03, effective 12/1/03]
[Filed emergency 6/14/04 after Notice 4/28/04—published 7/7/04, effective 7/1/04]
[Filed 8/12/04, Notice 6/23/04—published 9/1/04, effective 11/1/04]
[Filed emergency 9/23/04—published 10/13/04, effective 10/1/04]
[Filed 12/14/04, Notice 10/13/04—published 1/5/05, effective 2/9/05]
[Filed without Notice 5/4/05—published 5/25/05, effective 7/1/05]
[Filed emergency 9/21/05—published 10/12/05, effective 10/1/05]
[Filed emergency 11/16/05—published 12/7/05, effective 12/1/05]
[Filed 3/10/06, Notice 10/12/05—published 3/29/06, effective 5/3/06]
[Filed emergency 8/10/06 after Notice 3/15/06—published 8/30/06, effective 10/1/06]
[Filed emergency 9/14/06—published 10/11/06, effective 10/1/06]
[Filed emergency 11/8/06—published 12/6/06, effective 12/1/06]
[Filed 1/12/07, Notice 12/6/06—published 2/14/07, effective 3/21/07]
[Filed 3/14/07, Notice 10/11/06—published 4/11/07, effective 5/16/07]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
[Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 11/12/08]
[Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]

[Filed Emergency After Notice ARC 7957B (Notice ARC 7631B, IAB 3/11/09; Amended Notice ARC 7732B, IAB 4/22/09), IAB 7/15/09, effective 7/1/09]
[Filed ARC 9650B (Notice ARC 9497B, IAB 5/4/11), IAB 8/10/11, effective 10/1/11]
[Filed Emergency ARC 0191C, IAB 7/11/12, effective 7/1/12]
[Filed ARC 0306C (Notice ARC 0143C, IAB 5/30/12), IAB 9/5/12, effective 11/1/12]
[Filed ARC 0359C (Notice ARC 0193C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed Emergency ARC 0548C, IAB 1/9/13, effective 1/1/13]
[Filed ARC 0665C (Notice ARC 0547C, IAB 1/9/13), IAB 4/3/13, effective 6/1/13]
[Filed ARC 0757C (Notice ARC 0615C, IAB 2/20/13), IAB 5/29/13, effective 8/1/13]
[Filed Emergency ARC 0842C, IAB 7/24/13, effective 7/1/13]
[Filed ARC 1056C (Notice ARC 0841C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1445C (Notice ARC 1366C, IAB 3/5/14), IAB 4/30/14, effective 7/1/14]
[Filed Emergency After Notice ARC 2050C (Notice ARC 1982C, IAB 4/29/15), IAB 7/8/15, effective 7/1/15]
[Filed Emergency After Notice ARC 2164C (Notice ARC 2062C, IAB 7/22/15), IAB 9/30/15, effective 10/1/15]
[Filed ARC 2168C (Notice ARC 2095C, IAB 8/5/15), IAB 9/30/15, effective 11/4/15]
[Filed Emergency After Notice ARC 2361C (Notice ARC 2242C, IAB 11/11/15), IAB 1/6/16, effective 1/1/16]
[Filed ARC 2471C (Notice ARC 2114C, IAB 8/19/15; Amended Notice ARC 2380C, IAB 2/3/16), IAB 3/30/16, effective 5/4/16]
[Filed Emergency ARC 2848C, IAB 12/7/16, effective 11/15/16]
[Filed ARC 2936C (Notice ARC 2849C, IAB 12/7/16), IAB 2/1/17, effective 3/8/17]
[Filed ARC 3184C (Notice ARC 2920C, IAB 2/1/17), IAB 7/5/17, effective 8/9/17]

CHAPTER 108
LICENSING AND REGULATION OF CHILD-PLACING AGENCIES

[Prior to 7/1/83, Social Services [770] Ch 108]
[Prior to 2/11/87, Human Services [498]]

PREAMBLE

This chapter establishes licensing procedures for all child-placing agencies authorized by Iowa Code chapter 238. Included in this chapter are rules relating to: the licensing process; administration and organization; foster care services; adoption services; and supervised apartment living services.

441—108.1(238) Definitions.

"Administrator" means the person who is designated to have day-to-day responsibility for the administration of a child-placing agency, and who ensures that the mission of the agency and laws relating to the welfare and protection of children are carried out.

"Adoption work experience" means supervised employment in adoption services, which includes direct provision of adoption services, development of adoption policies, provision of training related to adoption services, oversight and review of adoption documents and activities, and direct supervision of adoption workers. Only the percent of time related to provision of adoption services shall be considered as adoption work experience when job duties involve activities other than adoption services.

"Adoptive applicant" means the person who has requested approval for placement of a child for adoption from a licensed child-placing agency.

"Adoptive family" means an approved person or persons who have a child placed in their home for the purpose of adoption and are being supervised by the agency or who have a child in their home who has been legally adopted and is entitled to the same benefits as a child born to the parents.

"Approved living arrangement" means that the living situation shall be located so as to provide reasonably convenient access to schools, places of employment, or services required by the youth, comply with applicable state and local zoning, fire, and sanitary regulations, and be reasonably priced so as to fit within the youth's budget.

"Caseworker" means the person who works directly with children, their families, and other relevant individuals and who has primary responsibility for the development, implementation, and review of the agency's service plans for the child and parents; or who completes foster care or adoptive family home studies or supervises foster family or adoptive placements; or who supervises children placed in approved supervised apartment living arrangements.

"Child" shall mean the same as defined by Iowa Code section 234.1.

"Child-placing agency" means an agency organized within the state of Iowa for the purpose of receiving minor children for placement, supervision, or both in private family homes for foster care; or for adoption; or the placement, supervision, or both of children who are 16 years of age and older living in approved supervised apartment living placements.

"Department" means the department of human services.

"Parent" means custodial and noncustodial parent.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Sibling" means two or more persons having at least one common parent.

"Supervised apartment living placement" means the placement of a child who is at least 16 years of age in an approved living arrangement which provides an environment in which the child can experience living in the community with minimum supervision.

"Volunteer" means any nonpaid person who donates time to an agency, either in working with an individual or groups of clients. A volunteer may also be a student intern.

[**ARC 1754C**, IAB 12/10/14, effective 2/1/15]

441—108.2(238) Licensing procedure.

108.2(1) *Right to apply.* Any person or agency has the right to make application for a child-placing license. When applying for a child-placing license, the applicant shall indicate the services for which licensure is being requested.

108.2(2) *Application.* An agency or person applying for a license shall complete Form 470-0723, Application for License or Certificate of Approval. The application shall be completed and signed by the administrator or the appropriate officer and submitted to the department.

a. The applicant shall report withdrawal of an application to the department within 30 days of the withdrawal decision.

b. Each application shall be evaluated by the department to ensure that all requirements are met.

c. The applicant shall provide requested reports and information relevant to the licensing determination to the department.

108.2(3) *Applications for renewal.* Applications for renewal shall be made to the department at least 30 but no more than 90 days before expiration of the license.

108.2(4) *Notification.* Agencies shall be notified of approval or denial within 90 days of application or reapplication.

108.2(5) *Certificate of license.* The department shall issue or renew Form 470-3623, Certificate of License, every three years, without cost, to any child-placing agency which meets the minimum requirements applicable to child-placing agencies as defined by Iowa Code chapter 238 and this chapter. The license shall be posted in a conspicuous place on the licensed premises.

108.2(6) *Provisional license.* A provisional license may be issued to an agency which does not meet all licensing requirements when the failure to meet all licensing requirements does not pose a danger to the health, safety, or well-being of the children being served. It is issued until the agency meets all requirements, up to a maximum time period of one year. A provisional license is issued when the applicant has signed a written statement which includes the following:

a. The deficiencies necessitating the provisional license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(7) *Suspension of a license.* The suspension of a child-placing license prohibits the agency from engaging in any child-placing activities during the period of the suspension. The department shall suspend a license when the agency's failure to meet the requirements poses a danger to the health, safety, or well-being of the children being served. The suspension of a license shall not extend beyond 12 months, and the existence of the condition requiring suspension shall be corrected within a year and documented in the agency's record.

The agency shall submit a written statement for approval by the department. The statement shall include the following:

a. The deficiencies necessitating the suspended license, including the specific requirements which are not met.

b. A plan for correcting the deficiencies.

c. The date by which the requirements will be met.

108.2(8) *Completed corrective action.* When the corrective action plan is completed on or before the date specified on the provisional license or notice of suspension, a full license shall be issued for the remainder of the licensing period.

108.2(9) *Denial or revocation of a license.* The department shall deny an application or reapplication for a license or revoke a license when the applicant fails to meet the licensing requirements or when any of the following conditions exist:

a. The agency is operating without due regard to the health, safety, and well-being of the children being served.

b. A provisional license is not approved.

c. The recipient of a provisional license fails to complete the corrective action plan within the time allowed.

d. An agency with a suspended license fails to complete the corrective action plan on time and a provisional license is not appropriate.

e. The agency misuses public funds.

f. The agency refuses to cooperate with child protective investigations involving children placed by the agency.

g. The agency continuously and significantly violates licensing requirements.

108.2(10) *Method and content of notice.* The notice of denial, revocation, or suspension shall be sent by restricted certified mail and shall include the following:

a. A specific description of the condition requiring the suspension, denial or revocation.

b. The specific laws or rules violated.

c. The effective date of denial, revocation or suspension.

108.2(11) *Right to appeal.* Any agency which disagrees with the department's licensing decision may appeal to the department. The appeal shall be filed within 30 days of receipt of the licensing decision.

441—108.3(238) Administration and organization.

108.3(1) *Statement of purpose.* The agency shall have a written statement of its child-placing philosophy, purpose, and program. The statement shall contain a description of services and methods for service delivery and a description of the persons for whom the services will be provided. The statement shall be available to the public.

108.3(2) *Governing board.* The agency shall have a governing board which, together with the executive, shall be responsible for making policy and for financing and general management of the agency. The governing board may be either the board of directors or the owners of the agency. If the governing board is a board of directors, the following rules shall apply:

a. The agency shall provide for continuity of board membership.

b. The board shall meet regularly for the purpose of ensuring the proper operation of the agency and fulfilling its responsibilities.

c. The minutes of each meeting of the board shall be kept and made a part of the permanent record of the agency.

108.3(3) *Annual report.* A child-placing agency shall require the administrator to submit a written annual report of the agency's activities. The report shall include fiscal and statistical sections indicating receipts and disbursements, number of clients served, and programs. The annual report shall be available to the department.

108.3(4) *Table of organization.* A table of organization, including the identification of lines of responsibility and authority for policy making and service to clients, shall be available to agency staff and to the department.

108.3(5) *Finances.* The licensee shall:

a. Annually develop and implement a plan of financing which is necessary for the operation of the agency in carrying out its programs, ensuring proper care for children, and meeting requirements for licensing.

b. Annually provide either an audit or a detailed financial statement prepared by an independent fiscal agency that provides a review of receipts and disbursements and a statement of fund balances.

c. Retain fiscal records for five years.

108.3(6) *Employment of administrator.* The agency shall employ a qualified administrator and shall delegate to the administrator the responsibility for the administration of the agency. The administrator shall ensure that the mission of the agency and laws relating to the welfare and protection of children are carried out.

108.3(7) *Office space, equipment and supplies.* The agency shall provide and maintain sufficient office space, equipment, and supplies to ensure delivery of services.

441—108.4(238) Staff qualifications.

108.4(1) *Qualifications for all staff.* A child-placing agency employee or volunteer shall be emotionally stable and have the experience and education to perform the duties assigned. The agency

shall not employ any person or give any person direct volunteer responsibility for a child or access to a child when the child is alone if that person has been convicted of a crime involving the mistreatment or exploitation of a child. The agency shall not employ any person or give any person direct volunteer responsibility for a child or access to a child when the child is alone if that person has a record of a criminal conviction or founded child abuse report unless the department has evaluated the crime or abuse and determined that the crime or abuse does not merit prohibition of volunteering or employment. If the child-placing agency is out of state, the agency shall complete that state's child abuse record check and a criminal record check.

a. If a record of criminal conviction or founded child abuse exists, the person shall be offered the opportunity to complete and submit Iowa's Record Check Evaluation form.

b. In its evaluation, the department shall consider:

(1) The nature and seriousness of the crime or founded abuse in relation to the employment or volunteer position sought;

(2) The time elapsed since the commission of the crime or founded abuse;

(3) The circumstances under which the crime or founded abuse was committed;

(4) The degree of rehabilitation; and

(5) The number of crimes or founded abuses committed by the person involved.

c. The agency shall maintain the following information with respect to each staff person:

(1) Documentation that a criminal record check with the Iowa division of criminal investigation has been completed on the staff person prior to the staff person's providing any care or service directly or indirectly to children under the care of the agency. A copy of the department's evaluation of the criminal record check shall be kept in the staff record.

(2) A written, signed and dated statement furnished by the staff person which discloses any founded reports of child abuse on the person that may exist prior to the staff person's providing any care or services to or on behalf of the facility.

(3) Documentation that a child abuse record check of the staff person has been completed with the Iowa central abuse registry for any founded reports of child abuse prior to the staff person's providing any care or services directly or indirectly to children under the care of the agency. A copy of the department's evaluation of this child abuse record check shall be kept in the staff record.

108.4(2) *Contracted employees.* A child-placing agency which contracts for services shall ensure that contracted employees meet the same qualifications, training, and evaluation requirements as those of workers in employed positions. A child-placing agency is responsible for the services provided by contracted providers as well as volunteers and agency employees.

108.4(3) *Qualifications of administrator.* An agency administrator shall possess one of the following:

a. A master's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and two years of experience in a public or private social services agency.

b. A bachelor's degree in social work, sociology, psychology, guidance and counseling, a related area of human services, education, business administration, or public administration and four years of experience in a public or private social services agency.

108.4(4) *Caseworker qualifications.* Therapy and counseling services, psychosocial evaluation and assessment and care plan development shall be provided by staff who meet one of the following minimum education and experience criteria:

a. Graduation from an accredited four-year college or university and the equivalent of three years of full-time experience in social work or experience in the delivery of human services in a public or private agency. In addition, these individuals shall have been employed by the agency prior to September 1, 1993. Persons meeting this criterion will not be qualified to provide therapy and counseling if they change place of employment.

b. Graduation from an accredited four-year college, institute or university with a bachelor's degree in social work from a program accredited by the council on social work education.

c. Graduation from an accredited four-year college or university with a bachelor's degree in a human service field related to social work and the equivalent of two years of full-time experience in social work or experience in the delivery of human services in a public or private agency.

d. Graduation from an accredited four-year college or university with a master's degree in social work or related human service field.

e. Any equivalent combination of graduate education in the social or behavioral sciences from an accredited four-year college or university and qualifying experience up to a maximum of 30 semester hours for one year of the required experience.

108.4(5) *Person filling more than one position.* A person functioning in more than one position specified by these rules shall meet the requirements for each of the positions the person fills.

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—108.5(238) Staffing requirements.

108.5(1) *Number of staff.* The agency shall employ a sufficient number of competent staff to perform duties as required by licensing rules for those programs operated by the agency. This shall include the following:

a. Administration of services offered by the agency.

b. Selection and appointment of qualified staff.

c. Provision for staff training.

108.5(2) *Staffing caseload.* The agency shall develop a written policy regarding a staffing ratio based on the workload necessary to provide services in accordance with the agency's program statements. The staffing ratio shall take into consideration all of the following:

a. Qualifications of the caseworkers.

b. Types of children served and their special needs.

c. Types and intensity of services to be provided.

d. Distances involved in provision of services.

e. Other functions or responsibilities of the caseworkers.

441—108.6(238) Personnel administration.

108.6(1) *Personnel policies.* An agency shall develop personnel policies in writing that identify responsibilities of the organization and staff. The policies shall specify hours of work, grievance procedures, sick leave, vacation and all other benefits. A copy of the policies shall be made available to the employee at time of hire.

108.6(2) *Job description and evaluation.* There shall be a written job description for each employee, volunteer, and contracted position identifying duties, qualifications, education, training requirements, and lines of authority. A copy shall be made available to the employees, volunteers, and contracted workers. There shall be a written evaluation of an employee's or contracted worker's performance within six months of being hired or contracted, and annually thereafter.

108.6(3) *Staff training.* An agency shall provide orientation training on the agency's purpose, policies and procedures within one month of hire and 24 hours of training in the first year of employment for all employed and contracted casework staff. The 24 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics, and 2 hours of training related to the identification and reporting of child abuse for all employed or contracted casework staff in accordance with Iowa Code section 232.69. An agency shall provide 12 hours of training per year after the first year of employment for all employed or contracted casework staff. The 12 hours of training shall include: training on family foster care services, adoption services, supervised apartment living services, or children and families' mental health topics and child abuse training every five years in accordance with Iowa Code section 232.69.

The training formats that shall qualify as training are as follows: in-service training, seminars, conferences, workshops, institutes, visiting other facilities, and meeting with consultants.

The training provided shall be documented. The documentation shall include the training topic, format, date and number of hours.

108.6(4) *Volunteers.* An agency which utilizes volunteer or student intern staff to work directly with a particular child or group of children shall have a written plan for using these volunteers. This plan shall be given to all volunteer staff and shall indicate that all volunteers are:

a. To be supervised directly by a paid staff member.

b. To be trained and oriented in the philosophy of the agency, the needs of the clients being served, and the methods of meeting these needs.

c. To be subject to the character and reference disclosure and checks required of employed and contracted applicants and employees.

d. To be subject to the same confidentiality rules as paid or contracted staff.

e. To assist and supplement paid staff only, and not replace them.

108.6(5) *Personnel records.* A confidential personnel record shall be maintained for each employee, contracted agent, and volunteer. The record shall contain all of the following information:

a. Name and address.

b. Record of training sessions attended, including dates and content of training.

c. Record of criminal convictions and the department's evaluation of same.

d. Record of founded child abuse reports and the department's evaluation of same.

441—108.7(238) Foster care services.

108.7(1) *Program statement.* An agency authorized to place children in foster care shall have a current written program statement. This statement shall be made available to all agency foster parents, foster children, their parents, referring agencies, and all persons making formal inquiry regarding foster care. The program statement shall include all of the following:

a. Types of foster care provided.

b. Types of children accepted for foster care.

c. Types of services provided to the children, their families, and their foster families.

d. Fees and application costs, if any.

e. A statement informing applicants of the right to appeal the agency's decision regarding nonapproval of the family for placement of a child for foster care.

108.7(2) *Agency's authorization to place.* The agency shall obtain a signed placement agreement from the child's custodial parent or legal custodian within 48 hours of placement.

108.7(3) *Preplacement documentation.* Except for emergency placements, a child shall be placed in the agency's foster care program only after the agency determines that its foster care program is an appropriate resource.

108.7(4) *Placement of siblings.* Preference shall be given to placing children from the same family together. If this is not in the best interest of the child, the reasons shall be documented in the child's record.

108.7(5) *Consideration of racial and cultural identity.* Race, color, or national origin may not be routinely considered in placement selections. Placement decisions shall be made consistent with the best interests and special needs of the child.

108.7(6) *Placement preparation.* An agency shall document the preparation for each child placed in foster care. Preparation shall be appropriate to the child's age, individual needs, the circumstances requiring placement, and the special problems presented. Preparation activities shall, when possible, include:

a. Face-to-face visits.

b. A description provided to the child of the foster family.

c. A description of the child's strengths and needs and safety-related information provided to the foster family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

d. Any other activities deemed significant.

108.7(7) *Initial placement outline.* If a placement outline is not in the child's case permanency plan, a brief outline documenting all of the following shall be entered in the child's case record within five working days after placement:

a. Name, birthdate, sex, race, and other significant identifying information.

b. Date of placement.

c. Name and address of parents or legal guardian.

d. Names and whereabouts of siblings.

e. Religious preference.

f. Immediate and significant health needs including the child's physical and emotional state at the time of placement.

g. The circumstances leading to the need for foster care.

h. Known previous out-of-home placements.

i. The immediate needs of the child and parents and services to be provided to meet these needs.

j. The name, address, and telephone number of the referring agent or worker.

108.7(8) *Education.* Within ten school days of placement, provisions shall be made by the agency for enrollment of each child of school age into a school program.

108.7(9) *Clothing.* An agency shall make provisions for adequate and individualized clothing for each child admitted into foster care.

108.7(10) *Monthly visit.* Each child in care shall be personally visited by the assigned caseworker at least once a month.

108.7(11) *Parent and child contact.* Provisions for contact between parents and children shall be made except where the parental rights have been terminated or where the court has determined that visits or contact are detrimental to the child.

a. If the mother is breastfeeding the child:

(1) An assessment shall be made whether continuation of breastfeeding is in the best interest of the child; and

(2) A plan shall be developed to support the mother's breastfeeding efforts, if appropriate.

b. The parents and child shall be informed of the contact plan in a manner consistent with their capacity to understand.

108.7(12) *Health and dental program.* An agency shall provide for a complete health and dental program for each child. An agency shall have a written procedure for handling medical emergencies on a 24-hour basis. A copy of the procedure shall be given to each foster home.

a. The agency shall obtain written authorization from the parent or legal guardian to provide medical, psychiatric, dental, anesthesia, immunization, substance abuse evaluation, and emergency surgical treatment. Only the parent or legal guardian shall consent to nonemergency surgery, unless ordered by court. If the child's parent prohibits medical examination, immunization, or treatment based on religious grounds, the agency shall obtain a signed statement from the parent that specifies the prohibitions. In potentially life-threatening situations, the agency shall refer the child's care to appropriate medical and legal authorities.

b. A child shall have a physical examination at least annually. This shall be performed by a licensed physician, physician's assistant or licensed nurse practitioner.

c. A child shall have current immunizations as required by the department of public health. If documentation of prior immunization is unavailable, immunizations shall begin within 30 days of placement, unless contraindicated and unless a statement from a physician to that effect is included in the child's medical record. A statement from physician, referring agency, parent, or guardian indicating immunizations are current is sufficient documentation of immunizations.

d. An agency shall provide for dental examinations and treatment; the initial referral at 12 months of age, the next at 24 months of age, then every 6 months.

e. A health record shall be maintained for each child and shall include all of the following:

(1) Authorization for medical care.

(2) A medical history and copies of required physical examinations.

(3) A record of medical and dental care, treatment and prescribed medication, immunizations, accidents requiring medical treatment, and hospitalizations. At the time of discharge from agency foster care, a summary of this record shall be provided to the legal custodian. Information about drug evaluation or treatment, venereal disease tests, HIV tests, and pregnancy tests shall be excluded.

108.7(13) *Service plan development and review.* The provider shall develop and revise service plans for each child in placement. An initial service plan shall be developed within 30 calendar days of placement in foster care. The provider shall identify qualified persons to monitor the services identified in the service plan to ensure that the plan continues to be necessary, appropriate, and addresses the permanency goal. Service plans shall be developed and reviewed as follows:

a. The service plan shall be developed and revised in collaboration with the referral worker, child, family, and the foster parents unless the service plan contains documentation for the treatment rationale for the lack of involvement of one of these parties. The provider shall document the dates and content of the collaboration on the initial and revised service plans. The provider shall provide a copy of the initial and revised service plans to the child's parent and the referring agency, unless otherwise ordered by the court. The initial and revised service plan shall identify the following:

(1) Strengths and needs of the child and parents.

(2) Goals, which are statements of outcomes to be achieved in meeting the needs of the child including the child's permanency needs.

(3) Objectives, which are specific, measurable and time-limited statements of indicators, levels of competence, or accomplishments which are necessary for progress toward each goal.

(4) Specific treatment service activities to be provided to achieve the objectives.

(5) Designation of the persons responsible for providing the services.

(6) Date of initiation and service plan development.

(7) Anticipated duration of services.

b. All service plans shall be reviewed 90 calendar days from the initiation of services and every 90 calendar days thereafter for the duration of the services or when the needs of the child or the services necessary for the parents to meet the needs of the child have changed and these changes significantly affect goals, objectives and service activities. The review shall determine if the services continue to be necessary, appropriate and consistent with the child's permanency goal. The reviewer shall revise the service plan to reflect the services that are necessary, appropriate, and consistent with the child's permanency goal.

108.7(14) *Information for foster parents.* At the time of placement, an agency shall provide foster parents with all of the following if known:

a. Name of the child, agency caseworker, and referring agency.

b. Information about the child's known behavioral characteristics including safety-related information, needs, and plans for the child and family. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court, or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. Written consent to obtain routine, nonsurgical medical care and to authorize emergency medical and surgical treatment, anesthesia, and immunizations for each child placed in the foster home.

d. A copy of the child's current physical examination and medical history when completed.

As this information becomes available to the agency, foster parents shall be informed immediately.

108.7(15) *Religious policy.* The agency shall have a written policy on religious participation and training for foster children. The agency shall provide the policy to parents and foster parents and shall ensure that the policy is adhered to in each foster home.

108.7(16) *Mail.* There shall be a written policy which ensures that foster children are permitted to send and receive mail, unless documented that this practice is contraindicated.

108.7(17) *Allowance policy.* An agency shall have a written policy addressing payment of and accounting for personal allowances for foster children.

108.7(18) *Reporting hospitalization or death of child.* Any serious injury or illness requiring hospitalization of a child in care shall be reported to the parent and the responsible agency as soon as possible. Efforts to notify parents and responsible agency staff shall be documented in the child's record. The death of a child shall be reported immediately to the parent or next of kin and to the referring agency.

108.7(19) *Foster care records.* The agency shall maintain confidential individual records for each child placed in a foster home. The record shall include:

a. The initial placement outline. (Refer to subrule 108.7(7).)

b. All legal documents pertaining to the child.

c. The child's health record, including psychological and psychiatric reports.

d. The summary narrative which reflects the dates and content of the caseworker's contact regarding the child.

e. Educational records and reports.

f. All service plans developed by the agency.

g. Case permanency plans developed by the referring agency.

h. A record of foster placements made by the agency including foster parents' names and addresses and dates of placements.

108.7(20) *Termination of foster care.* When a foster care placement is terminated, all of the following information shall be documented in the child's record within 30 days:

a. Reason for termination.

b. Current location of the child, unless the child was placed for adoption. In that case the record shall state only that the child was placed for adoption and shall not disclose the identity of the adoptive family unless the adoptive family agrees to disclosure of identity prior to finalizing of adoption.

c. Steps remaining to achieve permanency plan goal.

d. Provisions for follow-up, if any.

e. For unplanned terminations, a summary explaining the circumstances.

441—108.8(238) Foster home studies. The agency shall provide information to prospective foster parents about foster care, agency policies, licensing requirements for foster care, the children needing foster care, the licensing process and the reimbursement rates.

108.8(1) *Licensing procedures.*

a. Availability of applications. The agency may provide Form 470-0689, Foster Family Home License Application, to anyone requesting to be licensed.

b. Licensing study. The agency may complete a licensing study of the family.

c. New applications. If the child-placing agency decides to complete the initial licensing study, the agency shall submit to the department all documents and information required by 441—Chapter 113 pertaining to the licensing and regulation of foster family homes. This shall include a narrative evaluation of the foster family home which reflects a thorough study of each foster family. The narrative shall document at least two face-to-face interviews with the prospective foster family and at least one face-to-face interview with each member of the household before the placement of a child. At least one interview shall take place in the applicant's home. The narrative summary of the family study shall assess all of the following:

(1) Motivation for foster care.

(2) Family's and extended family's attitude toward accepting foster children.

(3) Family's attitude toward foster children's parents.

(4) Emotional stability, physical health, and compatibility of foster parents, and ways they cope with change and stress.

(5) Adjustment of own children, if any.

(6) Assessment of the child-caring skills, including disciplinary techniques used.

(7) Strengths and weaknesses of each member of the household.

(8) Types of children desired.

(9) Type of children, if any, for whom placement with the family would be appropriate.

(10) Recommendation as to the number, age, sex, characteristics, and special needs of children best served by this family.

(11) Assessment of the need for training and a plan for providing the needed training.

(12) Any other pertinent information that might assist the agency in making the licensing recommendation.

(13) Record checks. The licensed child-placing agency shall submit record checks for each applicant and for anyone who is 14 years of age or older living in the home of the applicant to determine whether they have any founded child abuse reports or criminal convictions or have been placed on the sex offender registry. The licensed child-placing agency shall use Form 470-0643, Request for Child Abuse Information, and Form 595-1396, DHS Criminal History Record Check, Form B, for this purpose. Each person subject to record checks shall also be fingerprinted for a national criminal history check. The department's contractor for the recruitment and retention of resource families shall assist applicants in completing required record checks, including fingerprinting. Any criminal or abuse records discovered shall be evaluated according to the procedures in rule 441—113.13(237).

(14) Health of foster parents and impact of medical conditions on their ability to foster a child.

(15) Income information.

(16) Documentation that at least three references have been received and the responses reviewed.

108.8(2) *Licensing decision.* The department shall make the licensing decision and notify the applicant and the child-placing agency within 30 days of the licensing decision. In no case shall a child be placed in a foster home before licensing approval.

a. A full license shall be issued to foster families meeting all necessary criteria for a full licensure.

b. A provisional license may be issued for up to one year if the foster family fails to meet all requirements for licensure. When an agency recommends, because of rule violation, that a foster home receive a provisional license at the time the license is issued or renewed, the agency shall document the violation in the foster home file, and shall send the following to the department:

(1) A copy of the assessment of the rule violation and recommendation.

(2) A copy of the foster home's plan to achieve rule compliance within stipulated time frames.

c. When an agency recommends that a foster home license be denied or revoked, the agency shall send the following documents to the department:

(1) A copy of the assessment of rule compliance and the foster family's reaction to the assessment.

(2) The agency's recommendation and supporting rationale.

(3) Other appropriate documents supporting the findings.

108.8(3) *Reapplications.* At least 30 days before the expiration of the license, the agency shall submit all documents and information required by 441—Chapter 113 pertaining to the licensing and regulation of foster family homes. This shall include an update of the narrative noting any changes that may have occurred in the foster family's living arrangement or life style and any other pertinent information that might assist in making the licensing decision, including an assessment of the foster family's ability to provide foster care.

108.8(4) *Unannounced visits.* The agency shall conduct at least one annual unannounced visit to each licensed foster family home the agency inspects to meet the requirements of Iowa Code section 237.7.

108.8(5) *Complaints.* When an agency receives a complaint which may indicate possible violation of the foster care licensing rules, the agency shall, within five working days of receiving the complaint, either conduct an investigation to assess compliance with applicable rules or refer the complaint to the department for investigation. If the agency conducts the investigation, the agency shall submit a written report of the investigation to the department within ten working days of receiving the complaint with a statement of rule violation and a recommendation regarding the license of the foster family home. The written report shall be filed in the foster parents' file.

108.8(6) *Foster family training.* The agency shall ensure that each foster home recommended for foster family license has complied with the training requirements in 441—113.8(237).

Within six months of licensure and every five years thereafter, each foster parent shall obtain mandatory reporter training relating to identification and reporting of child abuse.

108.8(7) *Placement agreement.* When a child is placed with a foster family, the agency shall have a signed agreement with each foster family home including the expectations and responsibilities of both the agency and the foster family, the services to be provided, and the financial arrangements for children placed in the home.

108.8(8) *Foster family home records.* The agency shall keep separate records for each foster family home. The agency shall begin the record at the time of application. Foster family home records shall contain:

a. The application.

b. Family assessment.

c. Most recent medical reports on foster family members.

d. Summary of dates and content of worker's contacts relating to licensing or relicensing.

e. Reference letters.

f. Annual assessment of strengths and weaknesses of the foster family relative to the care of individual children placed with them.

441—108.9(238) Adoption services.

108.9(1) *Program statement.*

a. An agency licensed to place children for adoption shall have a current written program statement which shall include all of the following:

(1) Characteristics of children to be placed.

(2) Eligibility requirements for adoptive families.

(3) Services provided during the adoption process.

(4) Services to the birth parents upon relinquishment.

(5) Postadoption services to adoptive families, if offered.

(6) Explanation of all fees and any other costs for which the adoptive family is responsible for payment.

(7) A statement that payment of fees does not ensure adoption approval.

(8) A statement informing applicants of the right to appeal the agency's decision regarding nonapproval of the family for placement of a child for adoption, or other adverse decisions.

b. The program statement shall be made available to referring agencies and to all persons making formal inquiry regarding adoption.

108.9(2) *Services to birth families.* An agency which offers services to birth parents who are considering relinquishing a child for adoption shall provide the following:

a. Intake process. When an agency agrees to provide services to the birth parents, intake interviews shall be conducted, including provision of information to the birth parents regarding the adoption process and their rights and role.

(1) When an agency completes a background information investigation report on the child to be adopted, a personal interview with each parent of the child must be completed unless a parent's identity or whereabouts is unknown.

(2) If a parent's identity or whereabouts is unknown, as much information as possible shall be obtained from the other parent or other sources if available.

b. Background information on birth parents. The agency shall obtain as much information as possible about birth parents that includes, but is not limited to:

(1) Birth parents' strengths and needs.

(2) Birth parents' physical description.

(3) Birth parents' and extended family members' medical and mental health history.

(4) Parents' criminal history.

(5) Birth parents' educational level.

(6) An affidavit signed by the birth parents instructing the court to reveal, or not reveal, their names to the child pursuant to Iowa Code chapter 600.

(7) Any additional information the birth parents wish to include in the child's adoption record.

c. Background information for an infant adoption. Information shall be obtained that includes, but is not limited to, the following:

(1) The child's due date.

(2) Prenatal care received by the mother during pregnancy.

(3) Risk factors that may affect the child's health after birth.

(4) Birth records following the child's birth, if available.

d. Background information on an older child. Information shall be obtained that includes, but is not limited to the following:

(1) The child's legal status.

(2) The child's physical description, medical and mental health history, developmental information, and other pertinent information necessary for a child study.

(3) Identification of any specific and unique needs of the child and the type of family to be considered for adoptive placement.

(4) The involvement of the birth parents and significant others in the child's care.

e. A copy of the background information of the child and birth parents shall be provided to the prospective family before placement of the child.

f. Birth parent counseling. If accepted by the birth parents, the counseling shall be provided after the birth of the child and prior to the signing of a release of custody that meets the requirements of Iowa Code chapter 600A or prior to the filing of a petition for termination of parental rights.

(1) The purpose of the counseling is to:

1. Provide information about options to assist birth parents in making an informed decision regarding release of custody.

2. Assist birth parents in resolving emotional issues related to separation and loss.

(2) Counseling shall be provided to birth parents only by the following persons:

1. Certified adoption investigators.

2. Mental health professionals who have the equivalent of two years of adoption work experience in the direct provision of adoption services.

3. Private agency staff with two years of adoption work experience in the direct provision of adoption services.

4. Department staff with two years of adoption work experience in the direct provision of adoption services.

(3) Forms. All forms used to execute a release of custody shall comply with the requirements of Iowa Code chapters 600 and 600A.

(4) Affidavit and documentation. The person providing the counseling shall complete the Counseling Affidavit to certify that the counselor has provided the birth parent with the requested counseling or that the birth parent has refused counseling. The Counseling Affidavit and documentation that the person providing the counseling is qualified to provide the requested counseling shall be attached to the release of custody. Documentation shall include one of the following:

1. A copy of a professional license, when applicable.

2. A record of all adoption work experience, including dates and location. In addition, the person providing counseling shall provide the names of the counselor's employers and supervisors to enable the court to verify the counselor's adoption work experience.

108.9(3) *Preparation of child for adoptive placement.* Preparing a child, especially an older child, includes activities designed to enable a child to make a transition to an adoptive placement. The activities shall include, but are not limited to:

a. Counseling regarding issues of separation, loss, grief, guilt, anger and adjustment to an adoptive family.

b. Preparation of a life book.

c. Provision of age-appropriate information regarding community resources available, such as children's support group to assist the child in the transition and integration into the adoptive family.

108.9(4) *Services to adoptive applicants.*

a. Application process. Before proceeding with an adoptive home study, the agency shall have received an application for adoption from the person or persons wishing to adopt a child. The application form shall include information about the applicant's intent to become an adoptive parent, and the basic data about the applicant's family, home, financial status, health, and references.

b. Explanation of the adoption process. The agency shall provide the applicant an explanation of the entire adoption process, including the legal procedures, the agency policies and procedures regarding placement of children, and the children available for adoption.

c. Adoptive home study. The home study consists of a family assessment which shall include at least two face-to-face interviews with the applicant and at least one face-to-face interview with each member of the household. At least one interview shall take place in the applicant's home. The assessment shall include, but need not be limited to, the following:

(1) Motivation for adoption and whether the family has biological, adopted or foster children.

(2) Family and extended family's attitude toward accepting an adopted child, and plans for discussing adoption with the child.

(3) The attitude toward adoption of other people involved with the family in a significant way.

(4) Emotional maturity; marital history, including verification of marriages and divorces; assessment of marital relationship; and compatibility of the adoptive parents.

(5) Ability to cope with problems, stress, frustrations, crises, separation and loss.

(6) Medical, mental, or emotional conditions which may affect the applicant's ability to parent a child.

(7) Ability to provide for the child's physical and emotional needs and to respect the child's cultural and religious identity.

(8) Description of biological and previously adopted children, if any, including their attitudes toward adoption, relationship with others, and school performance.

(9) Capacity to give and receive affection.

(10) Statements from at least three references provided by the family and other unsolicited references that the agency may wish to contact.

(11) Attitudes of the adoptive applicants toward the birth parents and the reasons the child is available for adoption.

(12) Income information, including the family's ability to financially provide for a child.

(13) Disciplinary practices that will be used.

(14) History of abuse involving family members, including how the abuse was addressed and how that history impacts the applicant's ability to be an adoptive parent.

(15) Assessment of, commitment to, and capacity to maintain other significant relationships.

(16) Substance use or abuse by members of the household, treatment history and current status of treatment.

(17) Recommendations for the number, age, sex, characteristics, and unique needs of children best parented by this family.

(18) The family's ability to anticipate and understand the unique needs of an adopted child as the child gets older and how the family will manage those needs.

d. Record checks. The licensed child-placing agency shall perform record checks for each applicant and for the other persons living in the home of the applicant as follows:

(1) The records of the applicants shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse Information form;

2. By the Iowa division of criminal investigation, using the DHS Criminal History Record Check Form B;

3. On the Iowa sex offender registry;

4. On the child abuse registry of any state where the applicant has lived during the five years prior to the issuance of the investigative report; and

5. For a national criminal history through fingerprinting or another biometric identification-based process accepted by the federal government.

(2) The records of persons aged 14 or older living in the home of the applicant shall be checked:

1. On the Iowa central abuse registry using the Request for Child Abuse Information form;

2. By the Iowa division of criminal investigation, using the DHS Criminal History Record Check Form B; and

3. On the Iowa sex offender registry.

(3) Out-of-state child abuse checks and national criminal history checks may be completed on any adult in the home of the applicant if the certified adoption investigator has reason to do so.

(4) The agency shall not approve a prospective applicant and the department shall not perform an evaluation if the applicant or anyone living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."*

(5) The agency shall not approve a prospective applicant and shall not perform an evaluation if the applicant or anyone living in the home of the applicant has committed a crime in a state other than Iowa that would be a forcible felony if the crime would have been committed in Iowa, as set forth in Iowa Code section 600.8(2)*"b."*

e. Evaluation of record. If the applicant or anyone living in the home has record of founded child abuse, a criminal conviction, or placement on the sex offender registry, the applicant shall not be approved to adopt unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of approval.

(1) The evaluation shall consider the nature and seriousness of the founded abuse or crime in relation to adoption, the time elapsed since the commission of the founded abuse or crime, the circumstances under which the abuse or crime was committed, the degree of rehabilitation, the likelihood that the person will commit the abuse or crime again, and the number of abuses or crimes committed by the person.

(2) The person with the criminal conviction or founded child abuse report shall complete and return the Record Check Evaluation form within 10 calendar days of the date on the form to be used to assist in the evaluation. Failure of the person to complete and return the form within the specified time frame may result in a written denial of approval for adoption.

(3) If the applicant, or anyone living in the home of the applicant, has been convicted of a simple misdemeanor or a serious misdemeanor that occurred five or more years prior to application, the evaluation and decision may be made by the licensed child-placing agency. The licensed child-placing agency shall notify the applicant of the results of the evaluation.

(4) If the applicant, or any person living in the home of the applicant, has a founded child abuse report, has been convicted of an aggravated misdemeanor or felony at any time, or has been convicted of a simple or serious misdemeanor that occurred within five years prior to application, the licensed child-placing agency shall initially conduct the evaluation.

1. If the licensed child-placing agency determines that the abuse or crime does warrant prohibition of approval, the licensed child-placing agency shall notify the applicant of the results of the evaluation in writing. The notice shall contain information on appeal rights.

2. If the child-placing agency determines that the applicant should be approved despite the abuse or criminal conviction, the agency shall provide copies of the Record Check Evaluation form and the written notice to the applicant to the Administrator, Division of Adult, Children and Family Services, Department of Human Services, 1305 East Walnut Street, Des Moines, Iowa 50319-0114. Within 30 days, the administrator shall determine whether the abuse or crime merits prohibition of approval and shall notify the child-placing agency in writing of that decision.

f. Agency decision. The licensed child-placing agency shall notify the applicant in writing no later than 30 days after completion of the home study of the agency's decision regarding approval for placement of a child.

(1) If the applicant is denied approval, the agency shall state the reasons for denial in the written decision.

(2) The agency worker and supervisor shall date and sign the adoptive home study.

(3) The agency shall provide a copy of the home study to the family at the time the written notice is sent.

(4) An agency shall not place a child in an adoptive home before the family is approved, or before a placement agreement is signed by the family and the agency.

(5) A home study shall be valid for up to two years from the date signed by the agency worker and supervisor.

g. *Denial.* The licensed child-placing agency shall deny approval of an adoption application when:

(1) The applicant or any other person living in the home of the applicant has been convicted of a felony offense as set forth in Iowa Code section 600.8(2)*"b."*

(2) The minimum standards set forth in these rules are not met and cannot be corrected.

(3) The applicant or any person residing in the home has been convicted of a crime, unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of approval.

(4) The applicant or any person residing in the home has a record of founded child abuse, unless an evaluation of the founded child abuse has been made by the department which concluded that the founded child abuse does not merit prohibition of approval.

(5) The application is fraudulent, which means the applicant has knowingly made false statements or has knowingly concealed information that is material to the investigation.

h. *Updates.* To remain valid, an update to the home study shall be completed no later than 24 months from the previous home study or previous home study update. The update shall be conducted by completion of the following:

(1) The child abuse and criminal history record checks, except for the national criminal history check, shall be repeated. Any abuses or convictions of crimes since the last record check shall be evaluated using the same process.

(2) A minimum of one home visit shall be conducted with the approved adoptive family.

(3) The information in the approved adoptive home study shall be reassessed.

(4) A written report of the assessment and updated adoptive home study shall be completed, dated, signed by the agency worker and the agency supervisor, and provided to the adoptive family.

i. *Annual visits to the adoptive home.* The agency shall complete a minimum of one visit each year in the homes of families approved to adopt by the agency.

(1) The visit shall include, but not be limited to, assessment of the following areas:

1. Home environment.
2. Persons present at the time of the visit.
3. Changes in the home or household members, or other areas addressed in the home study.

(2) When a person aged 14 or older moves into the home, the agency shall perform checks on the Iowa central abuse registry, by the division of criminal investigation, and on the sex offender registry. The record check evaluation process shall be completed if the person has a criminal conviction or founded child abuse report or is on the sex offender registry.

(3) The findings from the visit shall be documented and maintained in the file.

108.9(5) *Services to adoptive families.*

a. Preparation of the family includes activities designed to prepare the adoptive family for the placement of a particular child. These activities shall assist the adoptive family in expanding its knowledge and understanding of the child and enhance the family's readiness to accept the child into the family and encourage the family's commitment. The activities shall include, but not be limited to:

(1) Providing background information on the child and the birth family, including a child study.

(2) Providing information regarding the unique needs and characteristics of the child.

(3) Providing information regarding an older child's anticipated behavior.

(4) Discussing the impact that adding a new member to their family may have on all current family members.

(5) Discussing the issues of separation, loss, grief, anger, and guilt that adoptive children experience at various developmental stages.

(6) Providing the family with community resources that are available, such as support groups.

b. Preplacement services include the preplacement visits of the child and approved family and any activities necessary to plan, conduct, and assess these transitional visits before the placement of the child in the adoptive family's home for the purpose of adoption.

c. Postplacement services include postplacement supervision, support, crisis intervention, and required reports to the court. The postplacement services are provided from the time the child is placed with an approved adoptive family until finalization of the adoption occurs.

(1) No fewer than three face-to-face postplacement visits in the family's home are required.

(2) At a minimum the first visit shall be completed within 30 days after placement; the second visit within 90 days after placement; and the final visit before granting consent to adopt no later than 180 days after placement.

(3) Postplacement visits shall be completed as often as necessary if the adoptive family is experiencing problems, and may extend to finalization or beyond 180 days if additional time is needed.

d. Postplacement supervision. The agency shall provide postplacement supervision to assess the unique needs of the child including, but not limited to, the following areas:

(1) Integration and interaction of the child with the family.

(2) Changes in the family functioning which may be due to the child's placement.

(3) Social and emotional adjustment of the child.

(4) Child's growth and development since placement with the adoptive family.

(5) Changes and adjustments that have been made in the family since the child's placement.

(6) Family's method of dealing with testing behaviors and discipline.

(7) Behavioral evidence of the degree of bonding that is taking place and the degree to which the child is becoming a permanent member of the adoptive family.

(8) School adjustment of a child who is attending a school.

(9) The behavioral needs of the child.

(10) The psychological and mental health needs of the child.

(11) Services and supports that will assist the family in the future.

e. Postadoption services. The agency shall provide postadoption services to adoptive parents and adoptees, or shall refer adoptive parents and adoptees to other community resources for the services.

f. Postplacement reports. The agency worker shall prepare a written report based on observations made during each home visit. Each report shall address the specific needs of the child and the family's ability to meet those needs. The reports shall be used by the agency in making a written recommendation to the court regarding finalization of the adoption.

108.9(6) *International adoptions.*

a. International adoptions preplacement investigation. Preplacement investigations for the purpose of international adoptions shall meet the requirements of the United States Citizen Immigration Service.

b. International adoptions postplacement report.

(1) For an adoption based on a decree issued by a foreign jurisdiction within the United States, the agency shall conduct a postplacement investigation and issue a postplacement report as required in subrule 108.9(5).

(2) For an adoption based on a decree issued by a jurisdiction outside the United States, an investigator shall conduct a postplacement investigation that consists of a minimum of three face-to-face visits with the minor person and the adoptive parents during the first year after placement with the first such visit to be conducted within 60 days of the placement of the minor person in the adoptive home. Additional visits shall be conducted if required by the jurisdiction that issued the decree.

(3) The postplacement investigation and report under this subrule shall include documentation that any unique needs of the minor person are being met appropriately through the placement.

108.9(7) *Religious policy.* There shall be a written policy on religious participation for prospective placing parents, adoptive parents, and adoptees. The policy shall be made available to referral sources as well.

108.9(8) *Adoption records.* The agency shall keep separate records for each prospective, approved, or active adoptive family. Contents of these records shall be as follows:

a. The application.

b. The adoptive home study.

c. Current medical records.

d. All references.

e. All legal documents pertaining to the adoption.

f. Birth family information and background report, including physical descriptions, medical and mental health history, educational level, developmental history, problem areas such as substance or alcohol abuse.

g. Summary narrative on the placement decision and the preplacement and postplacement contacts with the adoptive family and child.

h. Information pertaining to the child including, but not limited to: physical, medical, and mental health; problem areas, including verification of the child's special needs; and whether or not a referral was made to the department for adoption subsidy.

i. In the event a family is not approved for placement of a child, the narrative shall clearly indicate the reason.

j. In the event a family is approved, but no child is placed with them, the narrative shall clearly indicate the reason.

108.9(9) *Right to appeal.* An adoptive applicant or an adoptive family may appeal an adverse decision made by a licensed agency. The appeal shall be filed with the department within 30 days of the notice of decision to the applicant or family by the licensed agency.

108.9(10) *Disposition of records.* When an adoption has occurred, the agency must maintain all records regarding the child, the birth family, and the adoptive family or families, forever. Any subsequent information received following the adoption finalization shall be placed in the adoption record. If the agency closes, all adoption records shall be forwarded to the department.

[**ARC 1754C**, IAB 12/10/14, effective 2/1/15]

441—108.10(238) Supervised apartment living placement services. An agency seeking to obtain a child-placing license which authorizes the agency to place or supervise children in supervised apartment living placements shall meet the standards in rules 441—108.2(238) to 441—108.6(238).

108.10(1) *Program statement.* An agency authorized to place or supervise children in supervised apartment living placements shall have a current written program statement which shall be provided to all children placed in supervised apartment living. The statement shall include all of the following:

a. A description of the types of living arrangements approved by the agency.

b. The eligibility requirements for the children who may be placed in a supervised apartment living placement.

c. The means of financial support for the children.

d. The expectations the agency has for children while placed in a supervised apartment living placement.

e. Services provided to the children.

f. Provisions for emergency medical care.

g. A description of the education and community activity options that are available.

108.10(2) *Basis for placement.* Before placing a child in supervised apartment living, an agency shall document all of the following:

a. The child is at least 16 years of age.

b. An initial assessment has been made that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

c. The child has the capacity to function outside the structure of a foster family or group care setting.

d. The selection of a supervised apartment living placement is the most appropriate placement for the child.

e. The child will be involved in school or an educational or vocational program, work, or a combination thereof, as indicated in the child's individual service plan.

f. The child has entered into a mutually agreed-upon written contract with the agency which specifies the responsibilities of the agency and the child. This contract shall be reviewed with the child quarterly.

g. The agency has determined, through a visit to the living arrangement, that the following minimum standards for approval have been met:

(1) The living arrangement provides reasonably convenient access to schools, places of employment, and services required by the child.

(2) The living arrangement is in compliance with the applicable state and local zoning, fire, sanitary, and safety regulations.

(3) The living arrangement is reasonably priced to fit within the child's budget.

h. The agency has determined, based on the criteria in this subrule, that the agency's program can meet the needs of the child.

108.10(3) *Services provided.* The following services are required:

a. Ongoing assessment that identifies the child's strengths and needs as these pertain to the child's ability to live independently.

b. Development of an individual service plan by the agency worker within 30 days of the child's placement. The service plan shall be developed in consultation with the child, the child's family (unless a reason for noninvolvement is documented in the case record), and referring worker and shall be signed by all involved. The individual service plan shall be reviewed and updated quarterly or more often as necessary and shall be signed by all involved. The plan shall document the following:

(1) The goals that are intended to meet the specific needs of the child and the projected dates of accomplishment.

(2) The objectives (action steps) to be taken by the child and the agency and the projected dates of accomplishment to meet the child's goals.

(3) The services and activities necessary to achieve the child's goals and facilitate objectives (action steps), the frequency of services or activities, and the persons responsible.

(4) A budget, developed with the child, based upon the child's monthly maintenance payment, any start-up allowance, and any earned or unearned income or assistance (such as food assistance). The agency worker shall work with the child to ensure that needed items are purchased and that bills are paid.

(5) In the quarterly update, the child's progress toward the goals and objectives and the child's compliance with the service plan.

c. Supervision to assist the child in developing the needed structure to live in this setting and in locating and using other needed services. Supervision shall include guidance, oversight, and behavior monitoring.

(1) If the child is under age 18, supervision shall include a minimum of weekly face-to-face contacts.

(2) For children aged 18 or older, supervision shall include face-to-face contact at least every other week.

(3) Agency staff shall be present on site in a cluster setting at any time when more than one child is present in the living arrangement and shall be available to the children 24 hours a day, seven days a week.

(4) The agency shall provide a means for children in a scattered site setting to contact agency personnel 24 hours a day, seven days a week.

(5) The agency shall ensure that each child has access to and is receiving necessary medical care.

d. Documented observation by the agency worker that:

(1) The living situation is an environment that allows for the child's social and emotional needs to be met;

(2) There is an operating smoke alarm on each level of occupancy;

(3) The child has access to a telephone; and

(4) There is no reasonable cause for believing that the child's mode of living presents any unacceptable risks to the child's health or safety.

108.10(4) *Record.* In addition to any other documentation requirements, an agency shall maintain a record for each child in a supervised apartment living placement. The record shall contain all of the following:

a. The name, date of birth, sex, and address of the child and information on how the child can be contacted.

b. Documentation of financial support sufficient to meet the child's housing, clothing, food, and miscellaneous expenses.

c. Name, address, and telephone number of guardian, if applicable, and referring worker.

d. Medical records.

e. Educational and employment records.

f. All of the individual service plans and updated reviews.

g. Documentation of visits.

108.10(5) *Staffing requirements.* Each child in a supervised apartment living placement shall receive an agreed-upon number of hours of casework services per month. This shall be recorded in the child's individual service plan.

[**ARC 8901B**, IAB 6/30/10, effective 9/1/10; **ARC 9730B**, IAB 9/7/11, effective 11/1/11]

These rules are intended to implement Iowa Code chapter 238.

[Filed December 14, 1967]
[Filed 6/25/76, Notice 5/17/76—published 7/12/76, effective 8/16/76]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]
[Filed 8/12/93, Notice 2/17/93—published 9/1/93, effective 11/1/93]
[Filed 1/12/94, Notice 11/24/93—published 2/2/94, effective 3/9/94]
[Filed emergency 12/15/94—published 1/4/95, effective 2/1/95]
[Filed 2/16/95, Notice 1/4/95—published 3/15/95, effective 5/1/95]
[Filed 6/13/96, Notice 4/24/96—published 7/3/96, effective 9/1/96]
[Filed 10/15/97, Notice 7/30/97—published 11/5/97, effective 1/1/98]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed 9/12/00, Notice 7/26/00—published 10/4/00, effective 12/1/00]
[Filed emergency 5/9/01—published 5/30/01, effective 5/9/01]
[Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 8/1/01]
[Filed 7/11/01, Notice 5/30/01—published 8/8/01, effective 10/1/01]
[Filed 11/18/02, Notice 8/21/02—published 12/11/02, effective 2/1/03]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed 11/16/05, Notice 9/28/05—published 12/7/05, effective 1/11/06]
[Filed emergency 6/14/07—published 7/4/07, effective 7/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed ARC 8901B (Notice ARC 8582B, IAB 3/10/10), IAB 6/30/10, effective 9/1/10]
[Filed ARC 9730B (Notice ARC 9563B, IAB 6/15/11), IAB 9/7/11, effective 11/1/11]
[Filed ARC 1754C (Notice ARC 1657C, IAB 10/1/14), IAB 12/10/14, effective 2/1/15]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

CHAPTER 112
LICENSING AND REGULATION OF CHILD FOSTER CARE FACILITIES

[Prior to 7/1/83, Social Services[770] Ch 112]
[Prior to 2/11/87, Human Services[498]]

441—112.1(237) Applicability. This chapter relates to licensing procedures for all child foster care facilities authorized by Iowa Code chapter 237. Rules relating to specific types of facilities are located in 441—Chapter 113, "Licensing and Regulation of Foster Family Homes," 441—Chapter 114, "Licensing and Regulation of All Group Living Foster Care Facilities for Children," 441—Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and 441—Chapter 116, "Licensing and Regulation of Residential Facilities for Children with an Intellectual Disability."

This rule is intended to implement Iowa Code chapter 237.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—112.2(237) Definitions.

"Applicant:"

1. For a foster family home license, the applicant is the person or persons applying.
2. For a proprietary child caring facility, the applicant is the owner of the facility.
3. For facilities having a board of directors, the applicant may be the president of the board or the board's designee.

"Community residential facility" means a facility which provides care for children who are considered unable to live in a family situation due to social, emotional or physical disabilities but are capable of interacting in a community environment with a minimum amount of supervision. The facility provides 24-hour care including board and room. Community resources are used for education, recreation, medical, social and rehabilitation services. The facility is responsible for planning the daily activities of the children, discipline, guidance, peer relationships, and recreational programs.

"Comprehensive residential facility" means a facility which provides care and treatment for children who are unable to live in a family situation due to social, emotional, or physical disabilities and who require varying degrees of supervision as indicated in the individual treatment plan. Care includes room and board. Services include the internal capacity for individual, family, and group treatment. These services and others provided to the child shall be under the administrative control of the facility. Community resources may be used for medical, recreational, and educational needs. Comprehensive residential facilities have higher staff to client ratios than community residential facilities and may use control rooms, locked cottages, mechanical restraints, and chemical restraints when these controls meet licensing requirements.

"Director's designee:"

1. For group facilities, the director's designee is the chief of the bureau of protective services.
2. For foster family homes, the designee is the department of human services' service area manager.

"Foster family home" means a home in which an individual person or persons or a married couple who wishes to provide or is providing, for a period exceeding 24 consecutive hours, board, room, and care for a child in a single family living unit.

"Group facility" means a community residential facility, a comprehensive residential facility, or a residential facility for children with an intellectual disability.

"Residential facility for children with an intellectual disability" means any residential facility which serves children with an intellectual disability as defined in Iowa Code chapter 222.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—112.3(237) Application for license.

112.3(1) *Right to apply.* Any adult individual or agency has the right to apply for a license.

a. *Foster family care.* A person wishing to apply to be a foster parent shall contact the department's recruitment and retention contractor in the applicable service area to request an application packet. This procedure also applies to:

(1) Persons wishing to care for children placed through any public or private agency.

(2) A relative who is caring for a child directly placed by the child's parents, guardians, or another relative and who wishes to be licensed as a foster parent.

b. *Group care.* A person wishing to apply for a group care license shall contact the department:

(1) Through the "Child Welfare" link on the department's Web site, www.dhs.iowa.gov; or

(2) By mail to the DHS Division of Child and Family Services, Attn: Group Care Licensing, 1305 East Walnut Street, Des Moines, Iowa 50319-0114.

112.3(2) *Decision to operate a facility.*

a. When an applicant has reached a decision to operate a foster family home, the applicant shall complete Form 470-0689, Foster Family Home License Application.

b. When an applicant has reached a decision to operate a group facility, the applicant shall complete Form 470-0723, Application for License or Certificate of Approval.

112.3(3) *Withdrawal of an application.* The applicant shall report the withdrawal of an application promptly to the department.

112.3(4) *Evaluation of the application.* Each application will be evaluated by the department to ensure that all standards are met.

a. Before it results in adverse action, a founded abuse report on a director, a sole proprietor involved in the facility's operation, or any facility staff or foster parent applicant shall be evaluated by the department to determine if the abuse merits prohibition of employment or licensure.

b. The department shall evaluate all founded child abuse on a case-by-case basis. Considerations shall include, but not be limited to:

(1) The facility's response (e.g., immediate termination of involved staff).

(2) Whether the abuse was an isolated incident or is symptomatic of a broader, systemic problem.

112.3(5) *Reports and information.* Requested reports and information relevant to the licensing determination shall be furnished to the department by the applicant.

112.3(6) *Applications for renewal.*

a. The department or its agent shall send the licensee an application for renewal 90 days before the license expires. Applications for license renewal shall be made on the form specified in subrule 112.3(2).

b. Applications for renewal shall be made at least 30 but no more than 90 days before the license expires. Applications for renewal of a group care license shall be submitted to the address in subparagraph 112.3(1)*"b"*(2). Applications for renewal of a foster family home license shall be submitted to the recruitment and retention contractor.

c. The department shall approve or deny an application for license renewal through the same process as that used for the original application.

112.3(7) *Notification.*

a. *Foster family homes.*

(1) The department shall notify an applicant of the approval or denial of an initial license within 140 days of the date that the applicant begins the preservice training required in 441—subrule 113.8(1). When preservice training is waived, the department shall notify the applicant of approval or denial within 120 days of the date that the training waiver is granted.

(2) The department shall notify a licensee of the approval or denial of license renewal within 90 days of reapplication.

b. *Group facilities.* The department shall notify a group facility of approval or denial of a license within 90 days of application or reapplication.

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—112.4(237) License.

112.4(1) A new license shall be obtained when the licensee moves or the facility is remodeled.

112.4(2) A new license shall be requested when the facility wishes to be licensed for a different number of children.

112.4(3) When corrective action is completed on or before the date specified on a provisional or renewal license, a full license shall be issued for the remainder of the licensure term.

112.4(4) When the corrective action is not completed by the date specified on a provisional or renewal license, a full license shall be denied.

112.4(5) The department shall issue Form 470-0727, Certificate of License, without cost to any foster family that meets the standards. The department shall issue Form 470-3623, Certificate of License, without cost to any group facility that meets the standards. The department may offer consultation to assist applicants in meeting the standards.

112.4(6) A foster family home license shall be approved for a term of one year for the first and second years of licensure. Thereafter, the license shall be approved for a term of two years unless it is determined by the administrator that a one-year license shall be issued. A group facility license shall be approved for a term of one to three years according to the following criteria:

a. A one-year license may be approved for all new agencies that meet licensure standards.

b. A two-year license may be approved upon completion of a survey for a renewal license when:

(1) Some health or safety concerns have been identified, but they are determined to be minor or easily corrected;

(2) Some complaints against a facility have been substantiated, but they are determined to be minor; and

(3) Deficiencies that have been identified are determined to be minor or easily corrected.

c. A three-year license may be approved upon completion of a survey for a renewal license when:

(1) No health or safety deficiencies have been identified;

(2) There have either been no substantiated complaints against the facility or, if substantiated, complaints have been determined not to be serious or severe; and

(3) A facility has no founded incidents of child abuse by facility staff.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 0356C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—112.5(237) Denial.

112.5(1) The department shall deny the license application when:

a. The minimum standards set forth in these rules are not met and a provisional license is inappropriate or disapproved by the director's designee.

b. For just cause.

c. The applicant, as a sole proprietor or a foster family home parent, or any person residing in the foster family home other than a foster child, or any facility staff, has been convicted of a crime unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of employment or licensure.

d. The applicant, as a sole proprietor or foster family home parent, or any person residing in the foster family home other than a foster child, or any facility staff, has a record of founded child abuse unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment or licensure.

e. The application is fraudulent, which means that the applicant has knowingly made fraudulent statements or has knowingly concealed information.

112.5(2) Reapplications shall be denied:

a. For the same reasons as original applications.

b. For the same reasons as listed in the grounds for revocation.

c. When the foster family applicant's license has been denied or revoked within the 12 months before the date of reapplication. Denial for this reason does not require a licensing study.

d. If the foster family refuses to engage as a resource to a foster child's birth parents when engagement can be done in a way that does not put the foster family or the foster child at risk of harm.

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—112.6(237) Revocation.

112.6(1) *Mandatory.* The department shall revoke the license for the following reasons unless subrule 112.6(3) applies:

a. When the facility is misusing funds furnished by the department.

b. When the facility is operating without due regard to the health, sanitation, hygiene, comfort, or well-being of the children in the facility.

c. When the director or sole proprietor involved in the operation of the facility, or foster parent, or any person residing in the foster home other than a foster child, or any facility staff has been convicted of a crime unless an evaluation of the crime has been made by the department which concludes that the crime does not merit prohibition of employment or licensure.

d. When there is a founded abuse report on a foster family home parent, any person residing in a foster family home other than a foster child, a director or sole proprietor who is involved in the facility's operation, or any facility staff, unless an evaluation of the founded abuse has been made by the department which concludes that the abuse does not merit prohibition of employment or licensure.

e. Rescinded, effective November 1, 1987.

112.6(2) *Optional.* Licenses may be revoked for any of the following reasons unless subrule 112.6(3) applies:

a. When moving to a new home, the foster family fails to notify the department and the recruitment and retention contractor within seven working days of the move to a new home.

b. Rescinded, effective July 1, 1987.

c. The foster family or facility fails to meet any or all requirements of the placement agreement.

d. Rescinded, effective July 1, 1987.

e. Rescinded, effective July 1, 1987.

f. The child foster care facility fails to continue to comply with all of the licensing requirements in both law and regulation.

g. The foster family or the staff of a licensed group facility refuses to cooperate with an unannounced visit.

112.6(3) *Exceptions.* The license for a foster family home shall not be revoked when there are 30 or fewer days until the date the license expires.

The foster family home shall be advised in writing that a reapplication may be denied and the reasons for the possible denial. The foster family home license may be suspended immediately pursuant to rule 441—112.9(237).

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 2069C**, IAB 8/5/15, effective 10/1/15]

441—112.7(237) Provisional license.

112.7(1) *Statement of reasons for provisional licenses.* Provisional licenses shall be accompanied by a statement of the reasons for the provisional license, the standards that have not been met, the date that the facility must make required changes to meet standards.

112.7(2) *Corrective action.* The facility shall furnish the licensing agency with a plan of action to correct deficiencies listed that resulted in the provisional license. The plan shall give specific dates upon which the corrective action will be completed.

This rule is intended to implement Iowa Code section 237.5.

441—112.8(237) Adverse actions. Notice of adverse actions and the right to appeal the licensing decision shall be given to applicants and licensees in accordance with 441—Chapter 7. Any issues of placement or payment are independent of the licensing decision and right of appeal.

This rule is intended to implement Iowa Code section 237.5.

441—112.9(237) Suspension.

112.9(1) *Types of suspension.* There are two types of suspension of a license.

a. Emergency suspensions are to prevent persons from providing foster care by suspending their license until it is revoked or denied.

b. Time-limited suspensions are to prevent persons from providing foster care by suspending their license until a deficiency in the home or facility is corrected.

112.9(2) *Requirements for emergency suspension.* The emergency suspension of a license by the director or designee shall occur only when all of the following conditions exist:

a. The licensee fails to meet licensing requirements.

b. There are sufficient grounds for revocation on denial of the license.

c. The health, safety, and welfare of any child placed in the home or facility requires immediate action.

d. The existence of the condition requiring suspension is documented in the licensee's record.

112.9(3) *Requirements for time-limited suspensions.* The time-limited suspension of a license by the director or designee shall occur only when all of the following conditions exist:

a. The licensee fails to meet licensing requirements.

b. The health, safety, and welfare of any child placed in the home or facility requires immediate action.

c. The existence of the condition requiring suspension is documented in the licensee's record.

d. The condition requiring the suspension can be corrected by the licensee to meet licensing requirements.

e. If the condition were corrected, a full license would be issued.

f. The licensee signs a written statement acknowledging the existence of the condition, citing the law or rule violated, and making a commitment to correct the condition within a specific time period, not to exceed the period of the license.

112.9(4) *Effective period of suspensions.* A suspension shall be effective on the date the notice is received by the licensee and shall remain in effect until one of the following occurs:

a. The department withdraws the suspension due to a change in conditions in the home or facility.

b. The court orders the license reinstated.

c. The action is reversed by a final decision in accordance with 441—Chapter 7.

d. For emergency suspensions, a revocation or denial becomes effective and the license is rescinded.

e. The licensing period expires.

f. For time-limited suspensions, the period of suspension ends.

112.9(5) *Method and content of notice.* The notice of suspension shall be sent by restricted certified mail or personal service and shall include the following:

a. The condition requiring the suspension.

b. The specific law or rule violated.

c. The type of suspension.

d. For an emergency suspension, the adverse action being sought by the department.

e. For a time-limited suspension, the duration of the suspension.

112.9(6) *Right to appeal suspension.* The licensee has the right to appeal the suspension of the license, but initiation of an appeal does not alter the suspension.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—112.10(232) Mandatory reporting of child abuse.

112.10(1) *Mandatory reporters.* The following foster care providers shall make a report, in accordance with Iowa Code section 232.69, whenever they reasonably believe a child for whom they are providing foster care has suffered abuse:

a. Any social worker who is employed by a licensed child foster care facility and who works with foster children.

b. Any licensed foster parent providing child foster care.

112.10(2) *Required training.* After completing the initial mandatory reporter training, and every five years thereafter, any person required to make a report under subrule 112.10(1) shall complete two hours of training relating to the identification and reporting of child abuse.

112.10(3) *Training provider.*

a. If the foster care provider is a social worker employed by a licensed child foster care facility, the employer shall be responsible for providing the required training in child abuse identification and reporting.

b. If the foster care provider is a licensed foster parent, the foster parent shall be responsible for obtaining the required two-hour training in child abuse identification and reporting as part of a continuing education program required under Iowa Code section 232.69 and chapter 272C and approved by the department of public health.

112.10(4) *Training content.*

a. Training in child abuse identification shall include physical and behavioral signs of physical abuse, denial of critical care, sexual abuse and other categories of child abuse pursuant to Iowa Code section 232.68.

b. Training in child abuse reporting shall include reporting requirements and procedures.

112.10(5) *Training documentation.*

a. If the foster care provider is a social worker employed by a licensed child foster care facility, the employer shall document in the employee's personnel record the content and amount of training.

b. If the foster care provider is a licensed foster parent, the foster parent shall be responsible for securing documentation of the training content, amount, and provider, and shall forward the documentation to the department's recruitment and retention contractor, which will provide a copy to the department licensing worker for the service area where the family resides for inclusion in the licensing file.

This rule is intended to implement Iowa Code section 232.69.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—112.11(237) Required training on the reasonable and prudent parent standard. Each group facility shall have an on-site official authorized to apply the reasonable and prudent parent standard as defined in rule 441—202.1(234). Within one year of being identified as an authorized on-site official, each authorized official shall complete the same department-approved training on the reasonable and prudent parent standard in the same manner as required for prospective foster parents and referenced in 441—subrule 117.1(4).

[**ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

[Filed 4/23/81, Notice 1/7/81—published 5/13/81, effective 7/1/81]
[Filed 11/20/81, Notice 9/30/81—published 12/9/81, effective 2/1/82]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed 10/1/85, Notice 7/31/85—published 10/23/85, effective 12/1/85]
[Filed 12/12/85, Notice 10/23/85—published 1/1/86, effective 3/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]
[Filed 4/9/04, Notice 3/3/04—published 4/28/04, effective 7/1/04]
[Filed ARC 8010B (Notice ARC 7712B, IAB 4/8/09), IAB 7/29/09, effective 10/1/09]
[Filed ARC 0356C (Notice ARC 0202C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 2069C (Notice ARC 1997C, IAB 5/27/15), IAB 8/5/15, effective 10/1/15]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

CHAPTER 113
LICENSING AND REGULATION OF FOSTER FAMILY HOMES

[Prior to 7/1/83, Social Services [770] Ch 113]
[Prior to 2/11/87, Human Services[498]]

441—113.1(237) Applicability. This chapter specifically relates to the licensing and regulation of foster family homes. Refer to 441—Chapter 112 for general licensing rules and regulations which apply to all foster care facilities, including foster family homes.

This rule is intended to implement Iowa Code chapter 237.

441—113.2(237) Definitions.

"Age- or developmentally appropriate activities" means activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

"Corporal punishment" means the intentional physical punishment of a foster child.

"Department" means the Iowa department of human services and includes the local offices of the department.

"Foster family home" means a home in which an individual person or persons or a married couple who wishes to provide or is providing, for a period exceeding 24 consecutive hours, board, room, and care for a child in a single family living unit.

"Health care provider" means a licensed medical doctor, doctor of osteopathy, physician assistant or advanced registered nurse practitioner who completes a health report.

"Public water supply system (PWS)" means a system for the provision to the public of water for human consumption through pipes or other constructed conveyances, if such system has at least 15 service connections or regularly serves an average of at least 25 individuals daily at least 60 days out of the year.

"Reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encourage the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, and social activities. For the purposes of this definition, "caregiver" means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution (including group homes, residential treatment, shelters, or other congregate care settings) in which a child in foster care has been placed.

"Reasonable force" means that force, and no more, which a reasonable person in like circumstances would judge to be necessary to prevent an injury or loss.

"Recruitment and retention contractor" means the entity that contracts with the department statewide to recruit foster and adoptive parents, complete home studies, and perform activities to support and encourage retention of foster and adoptive parents, or any of its subcontractors.

"Service area manager" means the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Social work administrator" means the department employee responsible for supervising the social work staff within a department service area and for implementing service policies and procedures of the department.

This rule is intended to implement Iowa Code chapter 237.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.3(237) Licensing procedure.

113.3(1) *Application.* Applications for an initial license to operate a foster family home shall be submitted and processed as directed in rule 441—112.3(237). In addition to the application form, the applicant shall submit the following forms during the licensing process:

a. Form 595-1396, DHS Criminal History Record Check, for each person living in the home who is 14 years of age or older, as required by rule 441—113.13(237).

b. Form 470-0720, Physician's Report for Foster and Adoptive Parents, to satisfy the requirements of rule 441—113.11(237).

c. Form 470-0693, Foster Care Private Water Supply Survey, if applicable.

d. Form 470-4657, Floor Plan. The applicant or the recruitment and retention provider shall complete a drawing of the floor plan of the family's home.

e. If licensed to drive, a copy of the driver's license and motor vehicle insurance.

113.3(2) *Orientation.* Applicants shall attend an orientation provided by the recruitment and retention contractor as described in rule 441—117.2(237).

113.3(3) *Record checks.* Before beginning preservice training, applicants shall pass at least the local record check procedures as specified in rule 441—113.13(237).

113.3(4) *Home study.* The worker for the recruitment and retention contractor shall complete a family home study.

a. *Process.* Information for the home study is gathered primarily through the required preservice training as described in rule 441—117.1(237). In addition:

(1) The worker shall hold at least two face-to-face interviews with the applicant with one of the interviews taking place in the applicant's home.

(2) The worker shall hold at least one face-to-face interview with each member of the household in the applicant's home.

(3) A physical inspection of the home is required. The worker shall use the Foster Family Survey Report to complete the physical inspection of the home to verify compliance with the licensing and regulation standards in this chapter.

(4) Reference checks shall be conducted as described at rule 441—113.14(237).

b. *Family assessment topics.* The assessment of the prospective foster family shall evaluate the family's ability to parent a special needs child. The assessment shall include the following:

(1) The applicant's motivation for foster care and whether the family has biological, adopted, or foster children.

(2) The attitude of the family and the extended family toward accepting a foster child.

(3) The applicant's emotional stability; marital relationship and history, including verification of marriages and divorces; family relationships; and compatibility.

(4) The applicant's ability to cope with problems, stress, frustrations, crisis, separation, and loss.

(5) Medical, mental, and emotional conditions that may affect the applicant's ability to parent a child; treatment history; current status of treatment; and the evaluation of the treatment.

(6) An evaluation of the applicant's willingness to accept a child who has medical problems (such as HIV), an intellectual disability, or emotional or behavioral problems. The applicant shall complete the department form to indicate choices about caring for children who have or are at risk for HIV infection and other medical problems.

(7) The applicant's ability to provide for a child's physical, medical, and emotional needs and respect the child's ethnic and religious identity.

(8) The safety of foster children in relation to any animals that live on the applicant's property.

(9) The adjustment of any children in the home, including their attitudes toward foster care and adoption, relationships with others, and school performance.

(10) An assessment of the applicant's disciplinary techniques and practices.

(11) The applicant's financial information and ability to provide for a child.

(12) The applicant's attitude toward the foster child's birth parents and siblings.

(13) The applicant's commitment to and capacity to maintain a foster child's significant relationships and work with the child's parents when the permanency goal is reunification.

(14) Any history of substance use or substance abuse by family members or members of the household, including treatment history and current status of treatment.

(15) Any history of abuse by family members or members of the household, including treatment history, current status of treatment, and how this issue would affect the applicant's ability to be a foster parent.

(16) Any criminal convictions of family members or adults in the household and the evaluation of the criminal record.

c. *Written report.* The recruitment and retention contractor shall prepare a written report of the family assessment using Form 470-5436, Resource Parent Home Study. The Resource Parent Home Study shall include a recommendation for the number, age, sex, characteristics, and special needs of a child or children the family can best parent and any other pertinent information in making the licensing recommendation. The home study shall be maintained in the foster family record.

113.3(5) *Decision.* The department worker shall use the home study to approve or deny a prospective family as an appropriate placement for a child or children. The department worker shall notify the family of the licensing decision using Form 470-0709, Notice of Action: Foster Family Home.

a. Upon approval, the department shall issue the applicant a foster family home license as described at rule 441—112.4(237). The license shall indicate the licensed capacity for the number of foster children approved for placement in the foster family home under subrule 113.4(1).

b. If the department worker does not approve the home study, the notice shall state the reasons for that decision, as listed in rule 441—112.5(237). A license denial may be appealed as described at rule 441—112.8(237).

This rule is intended to implement Iowa Code section 237.5.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.4(237) Provisions pertaining to the license. On a case-by-case basis, the service area manager or area social work administrator may waive any standard in this chapter unless:

1. The requirement is set in state or federal law; or
2. The waiver could have a negative impact on the safety and well-being of a child placed in the foster family home.

113.4(1) *Number of children.* A foster family home may care for up to five children unless a variance is approved as described in this rule. The license capacity shall be based on the number of the foster family's biological and adoptive children and any relative placements. The license shall be issued for at least one child. A child who has reached the age of 18 and remains eligible for foster family care shall be included in the license capacity. Any variance to this rule must:

a. Be approved by the service area manager or designee.

b. Be documented in the licensing record with reasons given for granting the variance.

c. Meet one of the following criteria:

(1) The foster parents have three or more children in the home and have shown the ability to parent a large number of children. A licensing variance may be approved at initial or renewal licensure to allow the placement of up to three foster children as set forth in the chart below:

No. of Children in the Home (birth/relative/adoptive placements)	Maximum License Capacity:	
	Without variance	With variance
0 children	5	Not applicable
1 child	4	Not applicable
2 children	3	Not applicable
3 children	2	3
4 children	1	3
5 or more children	Not applicable	3

(2) A variance beyond the maximum capacity of the foster home license is needed for the placement of a specific child in foster family care. A child-specific variance shall end when that child leaves the

placement or any other change brings the family into licensed capacity. Unless a variance is needed for the placement of a sibling(s) of a foster child already in the home, or to keep siblings together, the maximum number of children in the home shall not exceed eight. On a case-by-case basis, if it is determined the foster parents have shown the parenting skills and have the social support system to meet the children's needs for parenting more than eight children, the social work administrator shall approve the foster parents to parent more than eight children. A foster family may have both a licensing and a child-specific variance concurrently.

d. All other licensing requirements including, but not limited to, parenting ability and available bedroom space must be met before a foster home can be approved for a variance.

113.4(2) *Employees of the department as foster parents.* Employees of the department may be licensed as foster family home parents unless they are engaged in the administration or provision of foster care services. Employees engaged in the administration or provision of foster care services include:

a. Child care staff, social workers, youth service workers or their supervisors involved in programs for children in state institutions.

b. Foster care service workers, foster care licensing staff, and their supervisors employed in county or central offices of the department.

c. Other staff engaged in foster care placements, such as child protective staff or adoption workers.

d. Department staff responsible for the development of policies and procedures relating to foster care licensing and placement.

113.4(3) *Limits on foster family home licensure.* A licensed foster family home shall not be permitted to be a licensed comprehensive residential facility, community residential facility, or licensed child care center.

This rule is intended to implement Iowa Code sections 237.3 and 237.5.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.5(237) Physical standards.

113.5(1) *General standards.* The foster home shall be safe, clean, well ventilated, properly lighted, properly heated, and free from vermin and rodents to ensure the well-being of the foster children residing in the home.

113.5(2) *Grounds.*

a. There shall be safe outdoor space provided according to the age and developmental needs of the foster child for active play. The area available shall be documented in the case record.

b. The foster child shall be adequately supervised and protected against hazards including, but not limited to, traffic, bodies of water, railroads, waste material, and contaminated water. The foster parent shall provide environmental protections such as door alarms, baby monitors, fences, and foliage barriers.

c. When there is a swimming pool or child's plastic pool on the premises:

(1) A child's plastic pool shall be drained daily and shall be inaccessible to children when it is not in use.

(2) An aboveground or in-ground swimming pool that is not fenced shall be covered whenever the pool is not in use. The cover shall meet or exceed the ASTM International (formerly known as the American Society for Testing and Materials) specification intended to reduce the risk of drowning by inhibiting access to the water by children under five years of age.

(3) An uncovered aboveground swimming pool shall be enclosed with an approved fence that is nonclimbable and is at least four feet high. The height of the side of the pool may be included.

(4) An uncovered in-ground swimming pool flush with the ground shall be enclosed with an approved fence that is nonclimbable and is at least four feet high.

d. If children are allowed to use an aboveground or in-ground swimming pool, or other body of water:

(1) Equipment needed to rescue a child or adult shall be readily accessible.

(2) The foster parent or other adult shall provide reasonable supervision according to the ages and swimming abilities of the foster children when they are using the pool.

113.5(3) *Bedrooms for foster children.*

a. Bedrooms shall either have been constructed for the purpose of providing sleeping accommodation or remodeled for sleeping to provide proper heat and ventilation. Bedroom additions to a home shall meet building code requirements. All bedrooms used by foster children shall have:

(1) Permanent walls;

(2) A door that closes;

(3) An unobstructed, operable window that opens from the inside that is large enough to allow for an unrestricted exit by a foster child;

(4) A closet, wardrobe, armoire, or dresser for the child's clothes; and

(5) A standard bed, for infants and toddlers who cannot safely use a standard bed, a crib or crib-like furniture which has a waterproof mattress covering and sufficient bedding to enable a child to rest comfortably and which meets the current standards or recommendations from the U.S. Consumer Product Safety Commission or ASTM International for juvenile products for each child under two years of age if developmentally appropriate. The provider shall follow safe sleep practices as recommended by the American Academy of Pediatrics for infants under the age of one. Safe infant sleep practices shall conform to the following standards:

1. Infants shall always be placed on their backs for sleep.

2. Infants shall be placed on a firm mattress with a tight fitting sheet that meets U.S. Consumer Product Safety Commission federal standards.

3. Infants shall not be allowed to sleep on a bed, sofa, air mattress or other soft surface. No child shall be allowed to sleep in any item not designed for sleeping. This is not referring to a child in a car seat in a car.

4. No toys, soft objects, stuffed animals, pillows, bumper pads, blankets, or loose bedding shall be allowed in the sleeping area with the infant.

5. No co-sleeping shall be allowed.

6. If an alternate sleeping position is needed for an infant, a signed authorization with a statement of a medical reason is required and shall be submitted by a physician, advanced registered nurse practitioner, or physician assistant.

b. The minimum bedroom area per child shall be 40 square feet. However, the service area manager or designee may approve a smaller room size when approval is in the best interest of specific children placed or to be placed in the home. Such approvals shall:

(1) Be in writing;

(2) Contain the names and birth dates of the children for whom issued; and

(3) Be reviewed at each license renewal.

c. When bedrooms meet only minimum requirements, the home shall provide additional room in other parts of the home for study and play.

d. The ceiling height for bedrooms shall be adequate for the child.

e. Except for baby video monitors for children birth to two years of age used in their bedrooms, video or surveillance cameras are not allowed in children's bedrooms or bathrooms.

f. Bedrooms belowground shall:

(1) Be free from excessive dampness, noxious gases, and objectionable odors;

(2) Have access to at least one direct exit to the outside from the level belowground and one inside stairway exit from the level belowground;

(3) Have an egress window with a clear opening area with an opening height of 24 inches and an opening width of 20 inches or an opening height of 20 inches and an opening width of 24 inches;

(4) Have provisions, such as a ladder or steps, to ensure that the foster child can safely reach the window if the finished sill height is more than 44 inches above the floor and that the foster child can safely reach ground level if there is a window well that has a depth of 44 inches or higher;

(5) Have a finished ceiling such as drywall or a drop ceiling; and

(6) Have a covered floor.

113.5(4) *All rooms aboveground.* Rescinded IAB 10/3/12, effective 12/1/12.

113.5(5) *Rooms belowground.* Rescinded IAB 10/3/12, effective 12/1/12.

113.5(6) *Physical care standards for foster children.*

a. Grouping children in bedrooms shall take into consideration the age and sex of children.

(1) Children over 6 years of age shall not share a bedroom with a child of the opposite sex.

(2) Foster children shall not share a bed with any other child. The social work administrator may approve a waiver of this policy.

b. Children 2 years of age or older shall be provided bedroom space other than in the foster parents' bedroom. Foster children under the age of 2 may share a bedroom with the foster parent.

c. There shall be a plan for isolating healthy children from a child who is ill or suspected of having a contagious disease.

d. The foster home shall provide food with good nutritional content and in sufficient quantity to meet the individual needs of the children.

e. Bedding shall be clean, odor-free, and free of urine and feces.

f. Foster parents shall follow universal precautions to reduce exposure to bloodborne pathogens and other infectious materials when providing care to all children placed in their physical custody.

g. Smoking and vaping shall be prohibited in the foster home or any vehicle when the foster child is present.

113.5(7) *Lead-based paint.* If the applicant lives in a home built before 1960, the applicant shall submit Form 470-4819, Lead Paint Assessment, certifying that the applicant:

a. Has conducted a visual assessment for lead hazards that exist in the form of peeling or chipping paint; and

b. Has applied interim controls using safe work methods if the presence of peeling or chipping paint is found, unless an inspector certified pursuant to department of public health rules at 641—Chapter 70 has determined that the paint is not lead-based. "Interim controls" are measures designed to temporarily reduce human exposure or likely exposure to lead-based paint hazards, such as repairing deteriorated lead-based paint, specialized cleaning, maintenance, painting, and temporary containment.

113.5(8) *Artificial lighting.* Adequate artificial lighting fixtures shall be provided for study in areas where children will be studying.

113.5(9) *Toilet facilities.*

a. Toilet facilities shall have natural or artificial ventilation.

b. All toilet facilities shall be maintained in a clean and working condition.

113.5(10) *Heating plant.*

a. The heating plant shall have a capacity to maintain a temperature of approximately 65 degrees Fahrenheit in the bedrooms with the door closed.

b. Fireplaces and water heaters shall be vented to the outside atmosphere. Kerosene heaters and gas-fired space heaters shall not be used to heat any space in the home.

113.5(11) *Ventilation.* Ventilation shall be provided in all rooms where foster children eat, sleep, and play either by windows which can be opened or by mechanical venting systems. Windows and doors used for ventilation shall be screened.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0357C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.6(237) Sanitation, water, and waste disposal.

113.6(1) *Food preparation and storage.* Food preparation areas shall be clean, and there shall be facilities to store perishable food at cold temperatures and storage areas for other nonperishable food supplies.

113.6(2) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

113.6(3) *Private water supply.*

a. Each privately operated water supply shall be tested prior to initial licensure and tested before license renewal, and evaluated for obvious deficiencies such as open or loose well tops or platforms and poor drainage around the wells.

b. As part of the evaluation, water samples must be collected and submitted by the licensing worker or health sanitarian to the university hygienic laboratory or other laboratory certified by the hygienic laboratory and analyzed for coliform bacteria. In order to be licensed for the care of children under two years of age the nitrate (NO^3) content must be analyzed.

c. When the water supply is obtained from more than one well, proof of the quality of the water from each well is required.

d. When the water sample result shows the water is potable, the license can be granted.

e. When the water sample is not approved, no foster family home license shall be issued until the foster parents provide a written statement that foster children will be provided potable water, including where the water will be obtained and how it will be transported and stored.

(1) The statement shall be provided on Form 470-0699, Provisions for Alternate Water Supply.

(2) When the family has made ongoing alternative arrangements for the use of safe, potable water, annual testing of the water may be waived after the private water supply has tested unpotable for three consecutive years.

113.6(4) *Sewage treatment.*

a. Foster homes, wherever possible, shall be connected to public sewer systems.

b. Private disposal systems shall be designed, constructed and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

113.6(5) *Garbage storage and disposal.*

a. A sufficient number of covered garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly tight, watertight, and rodent proof and shall be maintained in a sanitary condition.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.7(237) Safety.

113.7(1) *Fire protection for bedrooms.* Any floor of a house, including the basement, shall be equipped with the following:

a. A working smoke detector. On floors that are used for sleeping, the smoke detector shall be in a location where sleeping areas can be alerted. For hearing-impaired children, the foster parent shall install a smoke detector in the child's bedroom that will use an alternative means of waking the child.

b. Hallways and stairways free of debris and clutter to allow unrestricted access to an exit.

c. A working carbon monoxide detector in all homes with:

(1) Gas appliances, furnaces, fireplaces, or other gas equipment; and

(2) Attached garages.

113.7(2) *Combustion hazards.*

a. Combustible materials shall be kept away from heat sources, including but not limited to furnaces, stoves, electrical panels, space heaters, and hot water heaters.

b. Explosives and flammable substances shall be stored securely and be inaccessible to a child. Matches and lighters shall be inaccessible to a child.

c. The home shall have at least one operable 2A-10BC-rated or ABC-rated fire extinguisher.

113.7(3) *Safety plan.* The family shall have an emergency safety plan to be used for fire, tornado, blizzard, flood, other natural or manmade disasters, accidents, medical issues, and other life-threatening situations for children in out-of-home placements. The safety plans shall state the action that the foster parents and children are to take in each situation that may occur.

a. The safety plans for fire and tornadoes shall be reviewed with foster children at the time of placement. Fire and tornado plans shall be practiced with the foster children within one week of placement and no less than annually thereafter.

b. In a disaster requiring evacuation of the foster home, the foster parents shall notify the department of the evacuation and the address and telephone number of the foster parents' temporary residence within 24 hours after evacuation.

c. The plans shall include a designated meeting place.

113.7(4) *Medications and poisonous substances.* All medications and poisonous, toxic, or otherwise unsafe substances shall be kept secured from access by children.

a. All prescription medication shall be administered as prescribed and documented in a medication log that is given to the child's department caseworker when the child leaves the placement.

b. All over-the-counter medications shall be administered according to label directions or as directed by a physician.

113.7(5) *Weapons.* All weapons, firearms, and ammunition shall be inaccessible to a child of any age.

a. Weapons and firearms shall be maintained in a locked place, such as a gun case.

b. Ammunition shall be maintained in a locked place separate from the firearms.

c. The weapons, firearms, and ammunition storage unit shall not share the same key or matching security code. If a key is used, the key shall be stored in a place inaccessible to the foster child.

d. Any motor vehicles used to transport foster children shall not contain a loaded gun, and any ammunition in the vehicle shall be kept in a separate, locked container.

e. Foster parents who have a permit to carry a firearm shall sign Form 470-4657, Firearms Safety Plan. Foster parents who have firearms but do not have a permit to carry shall complete the safety plan section of the Firearms Safety Plan form.

113.7(6) *Transporting foster children.*

a. Foster parents shall have a valid Iowa driver's license and adequate motor vehicle insurance when the foster parents transport foster children in a motor vehicle.

b. Foster parents shall ensure that appropriate child safety restraints, as required by Iowa law, are used for all foster children when the foster parents transport the children in a motor vehicle.

c. Any motor vehicles used to transport foster children shall be smoke-free when foster children are being transported.

113.7(7) *Supervision.* The foster parents shall provide reasonable and prudent supervision of foster children to ensure their safety.

a. Foster parents shall adequately supervise foster children while the children are using any hazardous or dangerous objects or equipment. In order for foster children to participate in age- or developmentally appropriate activities, the foster parent would apply the reasonable and prudent parent standard.

b. Foster parents shall use reasonable and prudent supervision of foster children when the foster children are using the Internet or other social media.

113.7(8) *Household pets.* Household pets and any outdoor animals or pets accessible to foster children shall have a current veterinary health certificate verifying that the animal's routine immunizations, e.g., rabies, are current.

a. At the time of the initial home study and any time thereafter, foster parents shall report an animal's history of aggression towards people and inform the department of the animal's aggression towards people within 24 hours of an occurrence.

b. Foster parents who have pets or animals with any history of aggression shall have a written plan that addresses strategies to reduce the risk of aggression by their pets or animals with which the child will have contact.

c. Animal waste will be contained and disposed of on a routine basis.

113.7(9) *Liability.* Foster parents who apply the reasonable and prudent parent standard reasonably and in good faith in regard to a foster child placed in their home shall have immunity from civil or

criminal liability which might otherwise be incurred or imposed. This subrule shall not remove or limit any existing liability protection afforded under any other law.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0357C**, IAB 10/3/12, effective 12/1/12; **ARC 2743C**, IAB 10/12/16, effective 12/1/16; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.8(237) Foster parent training.

113.8(1) *Preservice training.* All foster parent applicants shall complete the following training before licensure and the placement of a child in foster care in their home:

a. Orientation pursuant to rule 441—117.2(237);

b. Preservice training pursuant to rule 441—117.1(237);

c. Preservice training, which shall include:

(1) An agency-approved medication management training,

(2) A face-to-face cardiopulmonary resuscitation (CPR) and first-aid training,

(3) Mandatory reporter training on child abuse identification, and

(4) The reasonable and prudent parent standard training; and

d. Mandatory reporter training on child abuse identification and reporting before initial licensure and every five years thereafter as required by rule 441—112.10(232) and 441—subrule 117.8(3).

113.8(2) *In-service training.* All licensed foster parents shall complete six hours of in-service training annually as required by rule 441—117.7(237).

Each foster parent shall maintain certification in CPR and first-aid training.

This rule is intended to implement Iowa Code section 237.5A.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.9(237) Involvement of kin.

113.9(1) *Support by foster parents.* Foster parents shall support the involvement of biological or adoptive parents and other relatives of the foster child unless this involvement is evaluated and documented by the department to be detrimental to the child's well-being.

113.9(2) *Nature of involvement.* The extent and nature of the involvement of the biological or adoptive parents and other relatives shall be determined by the caseworker in consultation with the foster parents, biological or adoptive parents, and others involved with the child and family.

113.9(3) *Cultural connections.* Throughout the provision of care, the foster family shall actively ensure that the foster child stays connected to the child's kin, culture, and community as required in the child's case permanency plan.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.10(237) Information on the foster child.

113.10(1) *Foster child information.* Foster parents shall maintain a separate folder of information on each foster child placed in the foster family home. This folder shall be provided to the department or the child's parent or guardian when the child leaves the placement. The folder shall contain:

a. The names and addresses of all doctors, mental health professionals, and dentists who have treated the foster child; current medications prescribed, including over-the-counter medications; medication log; and the type of medical, dental, vision, and mental health treatments and hearing examinations received while the foster child is in the foster home.

b. School reports including report cards and pictures.

c. Date the child left the placement.

d. Name, address, and telephone number of the person to whom the child is discharged.

113.10(2) *Confidentiality.* Foster parents shall maintain confidentiality regarding a child in placement except as required to comply with rules on mandatory reporting of child abuse and with the child's case permanency plan. Foster parents shall not without parent or guardian and department

consent post pictures or information concerning a foster child on any Internet Web site or on social media.

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.11(237) Health of foster family.

113.11(1) *Health report required.* The foster parents shall furnish the licensing agency with a health report on the family completed no more than six months before the application for licensure. The report shall include information on all family members, including foster parents, their minor children who reside in the home, and adult household members. An updated report shall be provided upon request of the department licensing worker or the recruitment and retention contractor.

113.11(2) *Contents of report.* This report shall include a statement from the health practitioner that there are no physical or mental health problems which would be a hazard to foster children placed in the home and a statement that the foster parents' health would not prevent needed care from being provided to the child.

113.11(3) *Capability for caring for the child.* If there is evidence that the foster parent is unable to provide necessary care for the child, the department licensing worker, the recruitment and retention contractor, or the physician may require additional medical and mental health reports, including a substance abuse evaluation.

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.12(237) Characteristics of foster parents.

113.12(1) *Age.*

a. Foster parents shall be at least 21 years of age.

b. The age of foster parents shall be considered as it affects their ability to care for a specific child and function in a parental role.

113.12(2) *Income and resources.* The foster family shall have sufficient income and resources to provide adequately for the family's own needs.

113.12(3) *Religious considerations.* The foster parent shall respect the foster child's religious background and affiliation.

113.12(4) *Requirements of foster parents.* Foster parents shall be stable, responsible, physically able to care for the type of child placed, mature individuals who are not unsuited by reason of substance abuse, lewd or lascivious behavior or other conduct likely to be detrimental to the physical or mental health or morals of the child. They shall exercise good judgment in caring for children and have a capacity to accept agency supervision.

113.12(5) *Personal characteristics.* The foster parents shall:

a. Provide evidence of relationship stability.

b. Have realistic expectations of foster children.

c. Have time available to parent foster children.

d. Be able to accept and deal with acting out behavior with realistic expectations and good judgment.

e. Include foster children in normal family life.

f. Have the ability to be accepting and loving toward a foster child entering the home.

g. Be able to support the case permanency plan for the foster child and be willing to cooperate with visits, transportation, or other activities that support the child's connection to and reunification with the child's family.

h. Ensure that all family members are aware of having foster children in the home.

i. Articulate their strengths and concerns and limitations which are essential to the department's matching the foster children with foster parents appropriately.

113.12(6) *Determination of characteristics.* The areas discussed in subrules 113.12(4) and 113.12(5) shall be explored through observation of the family and interviews with family members and documented in a foster home study as described in subrule 113.3(4), or in the foster family record when explored after

licensure and prior to renewal. Any additional areas that the family or worker identifies as a possibility for creating problems shall also be documented in the foster family record.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.13(237) Record checks. Record checks are required for each foster parent applicant and for anyone who is 14 years of age or older living in the home of the applicant. The purpose of the record checks is to determine whether any of these persons has any founded child abuse reports or criminal convictions or has been placed on the sex offender registry.

113.13(1) *Procedure.* The department's contractor for the recruitment and retention of resource families shall assist applicants in completing required record checks, including fingerprinting.

a. Iowa records. Each foster parent applicant and anyone who is 14 years of age or older living in the home of the applicant shall be checked for records with:

(1) The Iowa central abuse registry, using Form 470-0643, Request for Child and Dependent Adult Abuse Information;

(2) The Iowa division of criminal investigation, using Form 595-1396, DHS Criminal History Record Check, Form B;

(3) The Iowa sex offender registry; and

(4) Iowa Courts Online.

b. Other records.

(1) Each foster parent applicant and any other adult living in the household shall also be checked for records on the child abuse registry of any state where the person has lived during the past five years.

(2) Each foster parent applicant shall also be fingerprinted for a national criminal history check. Fingerprinting, for the purpose of a national criminal history check, is required on all other adult household members at the time of initial application effective with applications dated on or after October 1, 2011. When warranted, the department may require fingerprinting for a national criminal history check on adult household members who move in after initial application.

113.13(2) *Evaluation of record.* If the applicant or anyone living in the home has a record of founded child or dependent adult abuse, a criminal conviction, or placement on the sex offender registry, the department shall not license the applicant as a foster family unless an evaluation determines that the abuse or criminal conviction does not warrant prohibition of license.

a. Exclusion. An evaluation shall not be performed if the person has been convicted of:

(1) A felony offense as set forth in Iowa Code section 237.8(2)*"a"*(4); or

(2) A crime in another state that would be a felony as set forth in Iowa Code section 237.8(2)*"a"*(4).

b. Scope. The evaluation shall consider the nature and seriousness of the founded child or dependent adult abuse or crime in relation to:

(1) The position sought or held,

(2) The time elapsed since the abuse or crime was committed,

(3) The degree of rehabilitation,

(4) The likelihood that the person will commit the abuse or crime again, and

(5) The number of abuses or crimes committed by the person.

c. Evaluation form. The person with the founded child or dependent adult abuse or criminal conviction report shall complete and return Form 470-2310, Record Check Evaluation, within ten calendar days of the date of receipt to be used to assist in the evaluation. Failure of the person to complete and return Form 470-2310 within the specified time frame shall result in denial of licensure.

113.13(3) *Evaluation decision.* The service area manager or designee shall conduct the evaluation and make the decision. The department shall issue Form 470-2310, Record Check Evaluation, to inform the subject of the decision and describe the basis of the decision using the criteria specified in paragraph 113.13(2)*"b."* The department shall mail the form to the person on whom the evaluation was completed:

a. Within 30 days of receipt of the completed Form 470-2310, Record Check Evaluation, or

b. When the person whose record is being evaluated fails to complete the evaluation form within the time frame specified in paragraph 113.13(2)*"c."*

113.13(4) *License renewal.* Foster parents applying for an annual or biennial license renewal shall be subject to the same checks as new applicants, except for fingerprinting. The department shall evaluate only abuses and convictions of crimes that occurred since the last record check. The evaluation shall be conducted using the same process.

This rule is intended to implement Iowa Code section 237.8(2).

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.14(237) Reference checks.

113.14(1) At least three additional unsolicited references shall be checked for all foster family home applicants in addition to a minimum of three references provided by the applicant.

113.14(2) Responses of references shall be documented in the applicant's record.

113.14(3) Information received from references may be discussed with the applicant at the discretion of the worker. The reference shall be so informed.

113.14(4) Reference checks shall include only those areas related to the applicant's ability to care for children and should include discussion of the following areas:

a. How long and in what capacity the reference has known the applicant.

b. Personal qualities of the applicant including the general character, ability to get along with others, ability to deal with children's problem behavior, ability to give affection and care, discussion of use of drugs and alcohol, questions regarding personal difficulties that could be detrimental to a foster child.

c. Relationship stability.

d. How the applicant handles anger, problems, crisis situations, discipline, and disappointments.

e. Any areas of general concern not previously mentioned.

f. Would the reference feel comfortable leaving a child in this home for a period of time?

g. Recommendations regarding licensing.

113.14(5) When warranted, additional references may be sought after licensure.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.15(237) Unannounced visits.

113.15(1) The department's recruitment and retention contractor shall make unannounced visits during periods of the day when the child and foster parents would normally be at home and awake, unless there has been a specific complaint about the family and care of the child.

113.15(2) The unannounced visit shall include, but is not limited to, assessment of the following areas:

a. Home environment.

b. Who was present at the time of the visit.

c. Interaction between the foster child and foster family and their children.

d. The foster child's perception of the foster parents, other children and adults in the home, behavioral expectations of foster parents, discipline used by foster parents, religious training, school, contact with natural parents, and purpose of placement in foster care.

e. The foster parents' view of the child, the child's problem, placement worker's involvement, plan for the child, involvement of natural parents, and additional services that either the foster child or foster parents need.

f. Any previously or currently cited deficiencies, corrective action plans and progress.

g. Any previous or current concerns from department workers.

h. Discussion of placements during the licensing year and, if none, the reason why.

i. Progress on completing training in the foster parents' training plan.

j. Awareness of the foster parents' license capacity and compliance.

k. Recommended action.

113.15(3) An unannounced visit to the foster home:

a. Shall be completed annually;

b. Shall not be waived; and

c. Shall not occur in conjunction with license renewal.

113.15(4) The findings from the unannounced visit shall be summarized on Form 470-5438, Progress Notes.

a. The report shall be sent to the department licensing worker and the foster parents within two weeks after the visit.

b. A copy of the report shall be retained in the foster parents' record.

113.15(5) Actions after the unannounced visit.

a. When deficiencies are cited that do not appear likely to cause immediate physical or mental harm to the child, an additional visit may be scheduled. The department licensing worker and the recruitment and retention contractor shall discuss the deficiencies with the foster parents and make plans for improving the deficiencies.

b. When the reported deficiencies raise questions of concern as to the quality of care provided, the recruitment and retention contractor shall:

(1) Report deficiencies to the department licensing worker and to the placement worker for each foster child currently placed in the home;

(2) Hold a meeting with the department licensing worker and the foster parents to discuss deficiencies and the plans for improving the deficiencies and then complete a written corrective action plan as to how the foster parents intend to address the deficiencies.

c. When the reported deficiencies appear likely to cause immediate physical or mental harm to the child, the service area manager or designee shall immediately:

(1) Direct the placement worker to determine if the child should be removed, and

(2) Direct the licensing worker to complete a review of the foster home to determine if the family should continue to be licensed, should receive a provisional license, or should have the license revoked according to 441—112.6(237).

113.15(6) When the foster parents refuse to make a written commitment to improve the deficiencies, the department licensing worker shall conduct a complete review of the foster home to determine if the license should be revoked according to rule 441—112.6(237).

This rule is intended to implement Iowa Code section 237.7.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.16(237) Planned activities and personal effects.

113.16(1) *Daily routine.* The daily routine shall promote good health and provide an opportunity for activity suitable for the foster child with time for rest and play.

113.16(2) *Clothing.*

a. All children should have their own clothing.

b. Children shall have training and help in selection and proper care of clothing.

c. Clothing shall be suited to the existing climate and seasonal conditions.

d. Clothing shall be becoming, of proper size, and culturally appropriate.

e. There shall be an adequate supply of clothing to permit laundering, cleaning and repair.

f. There shall be adequate closet and drawer space for children to permit access to their clothing.

113.16(3) *Educational opportunity.* Every foster child shall be given the opportunity to complete high school or vocational training in accordance with the child's case permanency plan. The foster parent shall be an advocate for the foster child by working with the foster child's school.

113.16(4) *Religion and culture.* Each child shall be given an opportunity, in consultation with the child's parents, to participate in the child's culture and religion. Children shall not be required to participate in religious training or observances contrary to the wishes of the biological or adoptive family or the religious beliefs of the child.

113.16(5) *Community participation.* Every child shall be given the opportunity to develop healthy social relationships through participation in neighborhood, school and other community and group activities. The child shall have the opportunity to invite friends to the foster home and to visit the home of friends.

113.16(6) *Work assignments.* Work assignments shall be in keeping with the child's age and development.

a. Exploitation of the child is prohibited. No child shall be permitted to do any hazardous tasks or to engage in any work which is in violation of the child labor laws of the state.

b. Each child shall have the opportunity to learn to assume some responsibility for self and for household duties in accordance with the child's age, health and ability. However, assigned tasks shall not deprive the child of school, sleep, play or study periods.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.17(237) Medical examinations and health care of the child.

113.17(1) *Medical and dental care.* Foster parents shall keep the child's department case manager informed of any medical and dental appointments and treatments prescribed for the child.

a. Foster parents shall contact the child's parents to engage them in the process of accessing routine medical and dental care for their child unless parental rights have been terminated.

b. In case of an emergency or urgent situation requiring medical care and treatment of an acute illness, disease or condition of a child, when a delay or inability to access parental or department consent for medical care or treatment would endanger the health or physical well-being of the child, the foster parents can provide consent for medical care and treatment.

113.17(2) *Exemption from medical care.* Nothing in this rule shall be construed to require medical treatment or immunization for a minor child of any person who is a member of a church or religious organization which is against medical treatment for disease. In such instance, an official statement from the organization and a notarized statement from the parents shall be incorporated in the record. In potentially life-threatening situations, the child's care shall be referred to appropriate medical and legal authorities.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.18(237) Training and discipline of foster children.

113.18(1) *Foster parents' methods of training and discipline.* The home study evaluation of each foster parent applicant shall include a discussion and a written report of the foster parents' methods of training and discipline. Discipline shall be designed to help the child develop self-control, self-esteem, and respect for the rights of others.

113.18(2) *Restrictions on training and discipline.* Child training and discipline shall be handled with kindness and understanding.

a. A child shall not be locked in a room, closet, box, or other device.

b. No child shall be deprived of food as punishment.

c. No child shall be subjected to verbal abuse, threats or derogatory remarks about the child or the child's family.

d. The use of corporal punishment is prohibited.

e. Restraints shall not be used as a form of discipline.

(1) Reasonable physical force may be used to restrain a child only in order to prevent injury to the child, injury to others, the destruction of property, or extremely disruptive behavior.

(2) Upon approval of the department, the foster parent may use restraints only in accordance with the written plan of a licensed mental health professional who is working with the child and the foster parents.

113.18(3) *Reports of mistreatment.* Reports of mistreatment coming to the attention of the department licensing worker and caseworker for the foster child shall be investigated promptly and referred to the proper authorities when necessary.

This rule is intended to implement Iowa Code sections 234.40 and 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—113.19(237) Emergency care and release of children.

113.19(1) *Supervision and arrangements for emergency care.*

a. Foster parents shall provide supervision of foster children and children in preadoptive placement as dictated by the individual child's specific needs.

b. In case of emergency requiring the foster parents' temporary absence from the home, arrangements shall be made with other licensed foster parents or with designated, responsible persons for the care of the children during the period of absence. The child's placement worker shall be notified of all emergency absences of the foster parents.

113.19(2) *Release of foster child.* The foster parents shall release the foster child only to the agency, parent or guardian from whom the child was received for care, or the person specifically designated by the agency, parent or guardian.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—113.20(237) Changes in foster family home. Foster parents shall notify the department and the recruitment and retention contractor within seven working days of:

1. Any change in the number of persons living in the home (except for foster children);
2. A move to a new home; or
3. Any circumstances in the home that could negatively affect the health, safety or welfare of a child in the family's care.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

[Filed 6/2/81, Notice 1/7/81—published 6/24/81, effective 8/1/81]
[Filed 8/24/81, Notice 5/27/81—published 9/16/81, effective 11/1/81]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed 10/1/85, Notice 7/31/85—published 10/23/85, effective 12/1/85]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]◊
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]◊
[Filed 7/13/89, Notice 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 8/14/92, Notice 6/24/92—published 9/2/92, effective 11/1/92]
[Filed 10/14/93, Notice 9/1/93—published 11/10/93, effective 1/1/94]
[Filed 3/20/95, Notice 1/18/95—published 4/12/95, effective 6/1/95]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
[Filed 3/11/98, Notice 1/14/98—published 4/8/98, effective 6/1/98]
[Filed 4/15/99, Notice 2/10/99—published 5/5/99, effective 7/1/99]
[Filed 5/9/01, Notice 3/21/01—published 5/30/01, effective 8/1/01]
[Filed 10/10/02, Notice 7/24/02—published 10/30/02, effective 1/1/03]
[Filed 11/18/02, Notice 8/21/02—published 12/11/02, effective 2/1/03]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06]
[Filed 9/19/06, Notice 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 6/14/07—published 7/4/07, effective 7/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed ARC 7606B (Notice ARC 7372B, IAB 12/3/08), IAB 3/11/09, effective 5/1/09]
[Filed ARC 8010B (Notice ARC 7712B, IAB 4/8/09), IAB 7/29/09, effective 10/1/09]
[Filed ARC 0357C (Notice ARC 0206C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 0356C (Notice ARC 0202C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 2069C (Notice ARC 1997C, IAB 5/27/15), IAB 8/5/15, effective 10/1/15]
[Filed ARC 2743C (Notice ARC 2652C, IAB 8/3/16), IAB 10/12/16, effective 12/1/16]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

◊ Two or more ARCs

CHAPTER 114
LICENSING AND REGULATION OF ALL GROUP LIVING FOSTER CARE FACILITIES FOR CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 114]
[Prior to 2/11/87, Human Services[498]]

441—114.1(237) Applicability. This chapter outlines the basic standards for all group living foster care facilities and contains the basic standards applicable to community residential facilities for children. Additional standards applicable to specific levels of group living are discussed in 441—Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and 441—Chapter 116, "Licensing and Regulation of Residential Facilities for Children with an Intellectual Disability."

This rule is intended to implement Iowa Code chapter 237.

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—114.2(237) Definitions.

"Adequate lighting" means a light intensity of 20 foot-candles (approximately equivalent to a 60 watt bulb at a clear distance of 5 feet).

"Caseworker" means any staff of the facility who is primarily responsible for planning for individual children, a family, or groups, as well as coordination with referral sources and coordination of services to the individual.

"Casework supervisor" means any staff of the facility who provides supervision of the caseworker(s) by regularly scheduled face-to-face case specific discussions with the caseworker.

"Chemical restraint" means the use of chemical agents including psychotropic drugs as a form of restraint. The therapeutic use of psychotropic medications as a component of a service plan for a particular child is not considered chemical restraint.

"Child care worker" means any staff of the facility whose primary responsibility is the direct care of children in the facility.

"Community residential facility" means a facility which provides care for children who are considered unable to live in a family situation due to social, emotional or physical disabilities but are capable of interacting in a community environment with a minimum amount of supervision. The facility provides 24-hour care including board and room. Community resources are used for education, recreation, medical, social and rehabilitation services. The facility is responsible for planning the daily activities of the children, discipline, guidance, peer relationships, and recreational programs.

"Control room" means a locked room used for treatment purposes in a comprehensive residential facility.

"Educational degrees" means formally approved certificates from accredited schools.

"Highly structured juvenile program" means a short-term treatment program lasting 90 days and having a high degree of structure that stresses discipline, physical activity, and education. The program must be licensed either as a community residential facility under this chapter or as a comprehensive residential facility under 441—Chapter 115. The program shall have the ability to use a physically secure setting dependent upon the level of the license.

"Locked cottage" means an occupied comprehensive residential facility or an occupied unit of a comprehensive residential facility which is physically restrictive because of the continual locking of doors to prevent the children in care from leaving the facility.

"Mechanical restraint" means restriction by the use of a mechanical device of a child's mobility or ability to use the hands, arms, or legs.

"Physical restraint" means direct physical contact required on the part of a staff member to prevent a child from hurting self, others, or property.

"Prime programming time" means any period of the day when special attention or supervision is necessary, for example, upon awakening in the morning until departure for school, during meals, after school, transition between activities, evenings and bedtime, or weekends and holidays, in order to maintain continuity of program and care. Prime programming time shall be defined by the facility.

"Private juvenile detention home" means a juvenile detention home as defined in Iowa Code section 232.2, which does not meet the requirements of being "county or multicounty" as defined in 441—subrule 105.1(2).

"Private juvenile shelter care home" means a juvenile shelter care home as defined in Iowa Code section 232.2, which does not meet the requirements of being "county or multicounty" as defined in 441—subrule 105.1(2).

"Prone restraint" means a physical restraint in which a child is held face down on the floor.

"Staff" means any person providing care or services to or on behalf of the facility whether the person is an employee of the facility, an independent contractor or any other person who contracts with the facility, an employee of an independent contractor or any other person who contracts with the facility, or a volunteer.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.3(237) Physical standards. Local building and zoning ordinances shall be met.

114.3(1) *Grounds.*

a. An outdoor play area of 75 square feet per child shall be provided.

b. The play area shall be identified and kept free from hazards that could cause injury to a child.

c. Rubbish and trash shall be kept separated from the play area.

d. The grounds shall be adequately drained.

114.3(2) *Buildings.*

a. All living areas shall:

(1) Have screens on windows used for ventilation.

(2) Be maintained in clean, sanitary conditions, free from vermin, rodents, dampness, noxious gases and objectionable odors.

(3) Be in safe repair.

(4) Provide for adequate lighting when natural sunlight is inadequate.

(5) Have heating and storage areas separated from sleeping or play areas.

(6) Have walls and ceiling surfaced with materials that are asbestos free.

b. All sleeping rooms shall:

(1) Provide a minimum of 60 square feet per child for multiple occupancy.

(2) Provide a minimum of 80 square feet per child for single occupancy.

(3) Not sleep more than four children per room. Facilities licensed prior to July 1, 1981, meeting current square footage requirements shall be allowed to house five children per room.

(4) Be of finished construction.

Facilities licensed prior to July 1, 1981, having a square foot area less than that required in subparagraphs (1) and (2) shall be considered to meet those standards.

c. All rooms aboveground shall:

(1) Have a ceiling height of at least 7 feet, 6 inches.

(2) Have a window area of at least 8 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

d. All rooms belowground shall:

(1) Have a ceiling height of at least 6 feet, 8 inches.

(2) Have a window area of at least 2 percent of the floor area unless mechanical ventilation is provided that is capable of removing dampness and odors.

(3) Have floor and walls constructed of concrete or other materials with an impervious finish and free from groundwater leakage.

114.3(3) *Bedrooms.*

a. Each child in care shall have a solidly constructed bed.

b. Sheets, pillowcases, and blankets shall be provided for each child and shall be kept clean and in good repair.

c. Each child in care shall have adequate storage space for private use, and a designated space for hanging clothing in proximity to the bedroom occupied by the child.

d. No child over the age of five years shall occupy a bedroom with a member of the opposite sex.

114.3(4) *Heating.*

a. The heating unit shall be located and operated to maintain the temperature in the living quarters at a minimum of 65 degrees Fahrenheit during the day and 55 degrees Fahrenheit during the night. Variances may be made in case of health problems. Temperature is measured at 24 inches above the floor in the middle of the room.

b. All space heaters and water heaters involving the combustion of fuel, such as gas, oil or similar fuel, shall be vented to the outside atmosphere.

c. Neither rubber nor plastic tubing shall be used as supply lines for gas heaters.

d. The heating or cooling plant shall be checked at least annually and kept in safe working condition at all times.

This rule is intended to implement Iowa Code section 237.3.

441—114.4(237) Sanitation, water, and waste disposal.

114.4(1) *Bathroom facilities.*

a. Bathrooms shall have an adequate supply of hot and cold running water.

b. Each bathroom shall be properly equipped with toilet tissue, towels, soap, and other items required for personal hygiene unless children are individually given these items. Paper towels, when used, and toilet tissue shall be in dispensers.

c. Toilets and baths or showers shall provide for individual privacy.

d. There shall be a shower or tub for each ten children or portion thereof.

e. Tubs and showers shall have slip-proof surfaces.

f. At least one toilet and one lavatory shall be provided for each six children or portion thereof.

g. Toilet facilities shall be provided with natural or artificial ventilation capable of removing odors and moisture.

h. Toilet facilities adjacent to a food preparation area shall be separated completely by an enclosed solid door.

i. All toilet facilities shall be kept clean.

j. When more than one stool is used in one bathroom, partitions providing privacy shall be used.

k. Toilets, wash basins, and other plumbing or sanitary facilities shall be maintained in good operating condition.

114.4(2) *Food preparation and storage.*

a. Cracked dishes and utensils shall not be used in the preparation, serving, or storage of food.

b. Storage areas for perishable foods shall be kept at 45 degrees Fahrenheit or below.

c. Storage areas for frozen foods shall be kept at zero degrees Fahrenheit or below.

d. Food that is to be served hot shall be maintained at 140 degrees Fahrenheit or above.

e. Food that is to be served cold shall be maintained at 45 degrees Fahrenheit or below.

f. The kitchen and food storage areas shall be kept clean and neat. Foods shall not be stored on the floor.

g. The floor and walls shall be of smooth construction and in good repair.

114.4(3) *Personnel handling food.* Personnel who handle food shall:

a. Be free of infection.

b. Be clean and neatly groomed.

c. Wear clean clothes.

d. Not use tobacco in any form while preparing or serving food.

114.4(4) *Dishwashing facilities.*

a. Manual dishwashing will be allowed in facilities that normally serve 15 or less people at one meal.

b. Commercial dishwashers shall be used in facilities serving more than 15 people at one meal, and shall meet the following criteria:

(1) When chemicals are added for sanitation purposes, they shall be automatically dispensed.

(2) Machines using hot water for sanitizing must maintain wash water at least 150 degrees Fahrenheit and rinse water at a temperature of at least 180 degrees Fahrenheit or a single temperature machine at 165 degrees Fahrenheit for both wash and rinse.

(3) All machines shall be thoroughly cleaned and sanitized at least once each day or more often if necessary to maintain satisfactory operating condition.

c. Soiled and clean dish table areas shall be of adequate size to accommodate the dishes for one meal.

d. All hand-held food preparation and serving equipment shall be cleaned and sanitized following each meal. Dispensers, urns, and similar equipment shall be cleaned and sanitized daily.

114.4(5) *Foods not prepared at site of serving.*

a. The place where food is prepared for off-site serving shall conform with all requirements for on-site food preparation.

b. Food shall be transported in covered containers or completely wrapped or packaged so as to be protected from contamination.

c. During transportation, and until served, hot foods shall be maintained at 140 degrees Fahrenheit or above and cold food maintained at 45 degrees Fahrenheit or below.

114.4(6) *Milk supply.* When fluid milk is used, it shall be pasteurized Grade A.

114.4(7) *Public water supply.* The water supply is approved when the water is obtained from a public water supply system.

114.4(8) *Private water supplies.*

a. Each privately operated water supply shall be annually checked and evaluated for obvious deficiencies such as open or loose well tops or platforms and poor drainage around the wells.

b. As part of the evaluation, water samples shall be collected and submitted by the department of human service worker or local health sanitarian to the state hygienic laboratory or other laboratory certified by the hygienic laboratory and analyzed for coliform bacteria and nitrate (NO^3) content.

c. When the water supply is obtained from more than one well, proof of the quality of the water from each well is required.

d. When no apparent deficiencies exist in the well and the water sample is approved, water safety requirements have been met.

e. When the water sample is not approved, the facility shall provide a written statement as to how the water supply will be upgraded.

f. A facility can obtain potable water from another source when a written statement is provided on where the water will be obtained and the manner of transportation and storage until the water supply is tested as safe. This shall be considered as meeting the water safety requirements.

114.4(9) *Heating or storage of hot water.* Each tank used for the heating or storage of hot water shall be provided with a pressure and temperature relief valve.

114.4(10) *Sewage treatment.*

a. Facilities shall be connected to public sewer systems where available.

b. Private disposal systems shall be designed, constructed, and maintained so that no unsanitary or nuisance conditions exist, such as surface discharge of raw or partially treated sewage or failure of the sewer lines to convey sewage properly.

114.4(11) *Garbage storage and disposal.*

a. A sufficient number of garbage and rubbish containers shall be provided to properly store all material between collections.

b. Containers shall be fly tight, leakproof, and rodent proof and shall be maintained in a sanitary condition.

This rule is intended to implement Iowa Code section 237.3.

441—114.5(237) Safety.

114.5(1) *General.*

a. Facilities shall take sufficient measures to ensure the safety of the children in care.

b. Stairways, halls and aisles shall be of substantial nonslippery material, shall be maintained in a good state of repair, shall be adequately lighted and shall be kept free from obstructions at all times. All stairways shall have handrails.

c. Radiators, registers, and steam and hot water pipes shall have protective covering or insulation. Electrical outlets and switches shall have wall plates.

d. Fuse boxes shall be inaccessible to children.

e. Facilities shall have written procedures for the handling and storage of hazardous materials.

f. Firearms and ammunition shall be kept under lock and key and inaccessible to children. When firearms are used, the facility shall have written policies regarding their purpose, use, and storage.

g. All swimming pools shall conform to state and local health and safety regulations. Adult supervision shall be provided at all times when children are using the pool.

h. The facility shall have policies regarding fishing ponds, lakes, or any bodies of water located on or near the institution grounds and accessible to the children.

114.5(2) *Emergency evacuation.* All living units utilized by children shall have a posted plan for evacuation in case of fire or disaster with practice drills held at least every six months.

114.5(3) *Fire inspection.* Each facility shall procure an annual fire inspection approved by the state fire marshal and shall meet the recommendations thereof.

114.5(4) *Local codes.* Each facility shall meet local building, zoning, sanitation and fire safety ordinances. Where no local standards exist, state standards shall be met.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 2743C**, IAB 10/12/16, effective 12/1/16]

441—114.6(237) Organization and administration. Any change in the name of the facility, the address of the facility, the executive, or the capacity shall be reported to the licensing manager.

114.6(1) *Table of organization.* A table of organization including the identification of lines of responsibility and authority from policymaking to service to clients shall be available to the licensing staff.

114.6(2) *Purpose of agency.* The purpose or function of the organization shall be clearly defined in writing and shall include a description of the children to be accepted for care and the services offered.

114.6(3) *Governing bodies or individuals.* All group living foster care facilities shall:

a. Have a governing board or individuals who are accountable for and have authority over the policies and activities of the organization. In the case of an organization owned by a proprietor or partnership, the proprietor or partner shall be regarded as the governing body.

b. Provide the department with a list of names, addresses, telephone numbers and titles of the members of the governing body.

c. Have adequate insurance covering fire and liability as a protection to children in care.

d. For organizations with the home base located outside Iowa, have duly authorized representatives with decision-making abilities designated within the state of Iowa.

114.6(4) *Executive director.* The governing body shall select and appoint an executive director with full administrative responsibility for carrying out the policies, procedures and programs established by the governing body.

114.6(5) *Financial solvency of facilities.* Profit and nonprofit institutions shall maintain financial solvency to ensure adequate care of children and youth for whom responsibility is assumed. It shall have sufficient financial resources, predictable income, or both, and not be totally dependent upon current fees, for a three-month operating period. The facility shall have written policies and procedures describing the program of the facility and specifying how it will be carried out.

This rule is intended to implement Iowa Code section 237.2.

441—114.7(237) Policies and record-keeping requirements.

114.7(1) *Policies in writing.* The following current personnel policies and practices of the agency and relating to the specific facility shall be described in writing and accessible to staff upon request:

a. Affirmative action and equal employment opportunity policies and procedures covering the hiring, assignment, and promotion of employees.

b. Job descriptions for all positions.

c. Provisions for vacations, holidays, and sick leave.

d. Effective, time-limited grievance procedures allowing the aggrieved party to bring the grievance to at least one level above that party's supervisor.

e. Authorized procedures, consistent with due process, for the suspension and dismissal of an employee for just cause.

f. Written procedures for annual employee evaluations.

114.7(2) *Health of staff.* Each staff person who has direct client contact or is involved in food preparation shall be medically determined to be free of serious infectious communicable diseases and able to perform assigned duties. A statement attesting to these facts shall be secured at the time of employment and filed in the staff record of the staff person. A new statement shall be secured at least every three years. The statement shall be signed by one of the following:

a. A physician as defined in Iowa Code section 135.1(4);

b. An advanced registered nurse practitioner who is registered with and certified by the Iowa board of nursing to practice nursing in an advanced role; or

c. A physician assistant licensed under Iowa Code chapter 148C.

114.7(3) *Staff records.*

a. The facility shall maintain the following information with respect to each staff person:

(1) Name and current address of each staff person.

(2) At least two written references or documentation of oral references. In case of unfavorable references, there shall be documentation of further checking to ensure that the person will be reliable.

(3) Documentation that a criminal records check with the Iowa division of criminal investigation has been completed on the staff person prior to providing any care or service directly or indirectly to children under the care of the agency. A copy of the department's evaluation of the criminal record check shall be kept in the staff record.

(4) A written, signed and dated statement furnished by the staff person prior to providing any care or services to or on behalf of the facility which discloses any founded reports of child abuse on the person that may exist.

(5) Documentation that a check of the staff person has been completed with the Iowa central abuse registry for any founded reports of child abuse prior to the person's providing any care or services directly or indirectly to children under the care of the agency. A copy of the department's evaluation of this child abuse record check shall be kept in the staff record.

(6) Records of a health examination or a record of a health report, as required in subrule 114.7(2), plus a written record of subsequent health services rendered to staff necessary to ensure that each individual is physically able to perform the job duties or functions.

(7) If the staff person has completed and submitted Form 470-2310, Record Check Evaluation, to the agency, a copy shall be kept in the staff record.

(8) Records of training sessions attended, including dates and content of the training.

(9) When otherwise required in situations that apply, a certified copy of a school transcript, diploma, or written statement from the school or supervising agency for positions having educational requirements.

b. In addition, with respect to staff who are employed by the facility, the facility shall maintain the following records:

(1) Social security number of each employee.

(2) A job application containing sufficient information to justify the initial and current employment.

(3) A certified copy of a school transcript, diploma, or written statement from the school or supervising agency before permanent employment of applicants for positions having educational requirements.

(4) Written verification of licensure before permanent employment of applicants for positions requiring licenses. Evidence of renewal of licenses as required by the licensing agency.

(5) Current information relative to work performance evaluation.

(6) Information on written reprimands or commendations.

(7) Information on position in the agency and date of employment.

(8) If the applicant, probationary or temporary employee has completed and submitted Form 470-2310, Record Check Evaluation, to the agency, a copy shall be kept in the staff record.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.8(237) Staff.

114.8(1) *Qualifications of staff.*

a. A caseworker shall have a bachelor of arts or bachelor of science degree in social work, psychology or a related behavioral science, plus two years of supervised experience; or a bachelor's degree in social work with one year of supervised experience; or six years of supervised child welfare experience in residential care or a combination of advanced education in the behavioral sciences and experience equal to six years.

b. A casework supervisor shall have either a master's degree in social work with one year of supervised experience after the master's degree or a master's degree in psychology or counseling with two years of experience beyond the master's degree, one of which was under supervision. The experience shall be in the area of child welfare services.

c. Child care workers shall be at least 18 years of age.

d. Any licensed facility having persons in employment in positions for which present rules require higher qualifications will be considered to meet rules with the present staff. New staff will need to meet the requirements of these rules.

e. A person who has a record of a criminal conviction or founded child abuse report shall not be employed, unless an evaluation of the crime or founded child abuse has been made by the department which concludes that the crime or founded child abuse does not merit prohibition of employment. If a record of criminal conviction or founded child abuse exists, the person shall be offered the opportunity to complete and submit Form 470-2310, "Record Check Evaluation." In its evaluation, the department shall consider the nature and seriousness of the crime or founded abuse in relation to the position sought, the time elapsed since the commission of the crime or founded abuse, the circumstances under which the crime or founded abuse was committed, the degree of rehabilitation, and the number of crimes or founded abuses committed by the person involved.

114.8(2) *Number of staff.*

a. Children shall be provided with 24-hour awake supervision. There shall be at least one awake and readily accessible staff person on duty for each currently occupied living unit. The staff person shall make regular visual checks at least every hour throughout the night. A log shall be kept of all checks, including the time of the check and any significant observations. Policies for nighttime checks shall be in writing.

b. Each facility shall have the services of a casework supervisor and a caseworker adequate to fulfill the staff duties.

c. There shall be an on-call system operational 24 hours a day to provide supervisory consultation. There shall be a written plan documenting this system.

d. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to eight staff to client ratio during prime programming time.

114.8(3) *Staff duties.*

a. The casework supervisor shall provide in-person case specific supervision at the site of the facility for one hour per month per caseworker and be available for consultation in case of emergency.

b. Caseworkers shall:

(1) Develop a care plan for each child containing goals and objectives with projected dates of accomplishment and shall involve the client, referral agency, and family whenever possible.

(2) Develop a specific plan relating to the involvement of the child's parents unless documented by the caseworker that their involvement would be counterproductive.

c. The facility shall define in writing who shall be responsible for the following staff duties:

(1) Documenting case reassessments quarterly, involving the same personnel as previously involved in care plan development.

(2) Documenting the implementation of the care plan.

(3) Providing for scheduled in-person conferences with each resident.

(4) Providing a supportive atmosphere for the child.

(5) Providing for coordination of internal and external activities of the child.

(6) Providing for liaison with the referring agency.

(7) Providing leadership and guidance to the children.

(8) Providing a mechanism for dealing with day-to-day program operations.

(9) Being responsible for overseeing and maintaining general health and well-being of children.

(10) Supervising the living activities of the children.

(11) Monitoring and recording behavior on a daily basis.

(12) At all times, knowing where the children are supposed to be.

114.8(4) *Staff development.* Staff development shall be appropriate to the size and nature of the facility. There shall be a written format for staff training that includes:

a. Orientation for all new employees to acquaint them with the philosophy, organization, program practices, and goals of the facility.

b. Training of new employees in areas related to their job assignments.

c. Provisions for all staff members to improve their competency. This may be accomplished through such means as:

(1) Attending staff meetings.

(2) Attending seminars, conferences, workshops and institutes.

(3) Visiting other facilities.

(4) Access to consultants.

(5) Access to current literature, including books, monographs, and journals relevant to the facility's services.

d. An individual designated responsible for staff development and training, who will complete a written staff development plan which shall be updated annually.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.9(237) Intake procedures.

114.9(1) *Intake policies.* The agency shall have written intake policies specific to the licensed facility.

114.9(2) *Basis of acceptance.* Children shall be accepted for care only after the following criteria have been met:

a. An assessment of the child's need for service and supervision has been agreed upon by the staff of the facility and the referring agency worker. The child, the child's family, and any other significant people shall be invited to participate in this process to the fullest extent possible.

b. The assessment indicates that the child requires the care offered by this type of facility and is likely to benefit from the program the facility offers.

114.9(3) *Referral requirements.* The following information shall be available prior to any decision being made regarding the acceptance of a child:

a. A current social history.

b. A copy of the child's physical assessment including immunization history completed within one year prior to application, when available.

c. Where indicated, or when available, psychological testing completed no more than one year prior to referral.

d. Current educational data.

e. When indicated or available, psychiatric report completed no more than one year prior to referral.

f. Referring agency's case plan which includes goals and objectives to be achieved during placement with a time frame for the achievement of these goals and objectives.

g. Documentation of the legal status of the child which includes any court orders or statements of custody and guardianship.

114.9(4) *Admission requirements.*

a. The following items shall be secured upon admission of the child to the facility.

(1) A placement agreement for the child signed by the person having legal responsibility for the child and the agency where the child is being placed. When this is not available at the time of placement, it shall be furnished within 48 hours of placement in the facility.

(2) Emergency medical authorization from the court, the parents, the guardian, or custodian.

b. The following items shall be provided to the child, the child's family or guardian, and the referring worker at the time of placement:

(1) A description of the services provided.

(2) Written policies regarding children's rights as in 114.13(2).

(3) Written policies regarding religion, work or vocational experiences, family involvement, grievance procedures and discipline as in 441—114.13(237) to 114.18(237) and 114.20(237).

114.9(5) *Personal assessment.* At the time of intake, individual needs will be identified by staff based on written and verbal information from referral sources, observable behavior at intake and the initial interview with youth or family, school contacts, physical examinations, and other relevant material. The individual assessment shall provide the basis for development of a care plan for each child.

114.9(6) *Educational assessment.* An educational assessment shall be developed by the staff and the referring worker. Involvement of the parents or guardian, area education agency, and public schools may be appropriate.

114.9(7) *Person responsible.* Each agency shall designate a person or persons who have the authority to do intake.

114.9(8) *Intake sheet.* An intake sheet shall be completed on each child containing at least the information specified in 114.11(2).

This rule is intended to implement Iowa Code section 237.3.

441—114.10(237) Program services.

114.10(1) *Evaluation services.*

a. When evaluation services are provided by staff of the facility, the services shall be clearly defined so that referral sources are clear about the components of the service.

b. Evaluations shall be based on behavioral observations, social history, educational assessments and shall include an assessment of vocational needs, recreational skills, and physical therapy, speech, language, vision and hearing needs to assist in planning and placement for the child. The need for providing all of these evaluative services will be determined on the basis of the specific child being referred.

114.10(2) *Care plan.* There shall be a written care plan for each child. The care plan shall be based on the individual needs determined through the assessment of each resident, provide for consultation with the family, and shall include the following:

a. Identification of special needs.

b. Description of planned services which indicate which staff person will be responsible for the specific services in the plan.

c. Indication of where the services are to occur and note the frequency of activities or services.

114.10(3) *Daily routine.* Each facility shall provide a daily routine for the children in residence which is directed toward developing healthful habits in eating, sleeping, exercising, personal care, hygiene, and grooming according to the needs of the individual child and the living group.

114.10(4) *Daily log.* The facility shall maintain a daily log. The log shall be used to note general progress in regard to the care plan and any problem areas or unusual behavior for each child.

114.10(5) *Educational services.* An educational program shall be available for each child in accordance with abilities and needs. The educational and teaching standards established by the state department of education shall be met when an educational program is provided within an institution.

114.10(6) *Health care.*

a. There shall be 24-hour emergency and routine medical and dental services available and provided when prescribed. Provisions for these services shall be documented.

b. The facility shall arrange a physical assessment including vision and hearing tests for each child in care within one week of admission unless the child has received an examination within the past year and the results of this examination are available to the facility.

c. A facility shall not require medical treatment when the parent(s) or guardian of the child or the child objects to treatment on the grounds that it conflicts with the tenets and practices of a recognized church or religious denomination of which the parent(s), guardian or child is an adherent. In potentially life-threatening situations, the facility shall refer the child's care to appropriate medical and legal authorities.

d. A facility shall have written procedures for staff members to follow in case of medical emergency.

e. A facility shall schedule a dental examination for each child within 14 days of admission unless the child has been examined within six months prior to admission and the facility has the results of that examination.

114.10(7) *Dietary program.* The facility shall provide properly planned, nutritious and inviting food and take into consideration the special food needs and tastes of children.

114.10(8) *Recreation and leisure activities.*

a. A facility shall provide the opportunity for recreation and leisure activities for children in care.

b. Opportunities shall be based on both the individual interests and needs of the children in care and the composition of the living group.

c. A facility shall utilize the recreational resources of the community whenever appropriate.

114.10(9) *Casework services.* A facility shall provide or obtain casework services in the form of counseling in accordance with the needs of each child's individual care plan. Casework services include crisis intervention, daily living skills, interpersonal relationships, future planning and preparation for placement as required by the child.

114.10(10) *Psychiatric and psychological services—(Optional service).*

a. When the diagnostic evaluation of a child indicates need for care by a psychiatrist and under psychiatric guidance, the specialized treatment or consultation shall be provided or arranged by the facility.

b. Psychologists, whose services are used in behalf of children, shall be licensed as a psychologist in the state of Iowa, or be certified by the department of education.

114.10(11) *Volunteers—(Optional service).* A facility which utilizes volunteers to work directly with a particular child or group of children, shall have a written plan for using volunteers. This plan shall be given to all volunteers. The plan shall indicate that all volunteers shall:

a. Be directly supervised by a paid staff member.

b. Be oriented and trained in the philosophy of the facility and the needs of children in care, and methods of meeting those needs.

c. Be subject to character and reference checks required of employment applicants.

114.10(12) *Liability.* Licensed group living foster care facilities that apply the reasonable and prudent parent standard reasonably and in good faith in regard to a child in foster care shall have immunity from civil or criminal liability which might otherwise be incurred or imposed. This subrule shall not remove or limit any existing liability protection afforded under any other law.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 2743C**, IAB 10/12/16, effective 12/1/16]

441—114.11(237) Case files.

114.11(1) *Generally.* All facilities shall establish and maintain case files on each child. The case files shall include the following:

114.11(2) *Face sheet.* The face sheet shall contain the following information:

a. Full name, birth place and date of birth.

b. Parents' full name.

c. Parents' address and telephone number.

d. Religious preference of parents and child.

e. Statement of who has legal custody and guardianship.

f. Name of the referring worker and agency making the referral.

g. Telephone number and address of the agency or court making the referral.

114.11(3) *Referral packet.* All of the information required in the referral packet shall be contained in the case record including a social history on the child, a copy of the child's physical assessment and immunization history, psychological testing, when available, current educational information, psychiatric report, when available, and the referring agency's case plan.

114.11(4) *Legal documents.*

a. Placement agreement signed by parent(s) or custodian of the child.

b. Petitions and orders of the court regarding adjudication, custody, or guardianship.

114.11(5) *Psychiatric and psychological.* Psychiatric and psychological reports, when available.

114.11(6) *Correspondence.* Correspondence regarding the child.

114.11(7) *Medical.*

a. Medical and surgical authorizations signed by the parent(s), guardian, or contained in the court order.

b. Record of medical care received while in the facility.

c. Information on past medical history.

114.11(8) *School.*

a. Name of school currently attended.

b. Grade placement.

c. Any specific educational problem.

d. Remedial action recommended.

114.11(9) *Care plan.* Individual child care plan and semiannual review and revision of care plan.

114.11(10) *Dictation.*

a. Appropriate notes, all significant contacts with parents, referring worker and other collateral contracts, as well as staff counseling with child and notations on behavior.

b. Information on release of the child from the facility including the name, address and relationship of the person or agency to whom the child was released.

This rule is intended to implement Iowa Code section 237.3.

441—114.12(237) Drug utilization and control. The agency shall have written policies and procedures governing the methods of handling prescription drugs and over-the-counter drugs within the facility. No prescription or narcotic drugs are to be allowed in the facility without the authorization of a licensed physician.

114.12(1) *Approved drugs.* Only drugs which have been approved by the federal Food and Drug Administration for use in the United States may be used. No experimental drugs may be used.

114.12(2) *Prescribed by physician.* Drugs shall be prescribed by a physician licensed to practice in the state of Iowa or the state in which the physician is currently practicing and may be prescribed only for use in accordance with dosage ranges and indications approved by the federal Food and Drug Administration.

114.12(3) *Dispensed from a licensed pharmacy.* Drugs provided to residents shall be dispensed only from a licensed pharmacy in the state of Iowa in accordance with the pharmacy laws in the Code of Iowa, or from a licensed pharmacy in another state according to the laws of that state, or by a licensed physician.

114.12(4) *Locked cabinet.* All drugs shall be maintained in a locked cabinet. Controlled substances shall be maintained in a locked box within the locked cabinet. The cabinet key shall be in the possession of a staff person. A bathroom shall not be used for drug storage. A documented exception can be made by a physician for self-administered drugs as discussed in 114.12(17).

114.12(5) *Medications requiring refrigeration.* Medications requiring refrigeration shall be kept in a locked box in the refrigerator and separated from food and other items.

114.12(6) *Poisonous or caustic drugs.* All potent poisonous or caustic drugs shall be plainly labeled, stored separately from other drugs in a specific well-illuminated cabinet, closet, or storeroom, and made accessible only to authorized persons.

114.12(7) *Prescribed medications.* All prescribed medications shall be clearly labeled indicating the resident's full name, physician's name, prescription number, name and strength of the drug, dosage, directions for use and, date of issuing the drug. Medications shall be packaged and labeled according to state and federal guidelines.

114.12(8) *Medication containers.* Medication containers having soiled, damaged, illegible or makeshift labels shall be returned to the issuing pharmacist.

114.12(9) *Medication for discharged residents.* When a resident is discharged or leaves the facility, medications currently being administered shall be sent, in the original container, with the resident or with a responsible agent, and with the approval of the physician.

114.12(10) *Unused prescription drugs.* Unused controlled prescription drugs prescribed for residents shall be returned to the issuing pharmacist or physician for credit or destruction according to state law. Other unused prescription drugs shall be destroyed by facility staff in the presence of a witness and this destruction shall be documented.

114.12(11) *Refills.* Prescriptions shall be refilled only with the permission of the attending physician.

114.12(12) *Use of medications.* No prescription medications prescribed for one resident may be administered to or allowed in the possession of another resident.

114.12(13) *Order of physician.* No prescription medication may be administered to a resident without the order of a licensed physician.

114.12(14) *Patient reaction.* Any unusual patient reaction to a drug shall be reported to the attending physician immediately.

114.12(15) *Dilution or reconstitution of drugs.* Dilution or reconstitution of drugs and their labeling shall be done only by a licensed pharmacist.

114.12(16) *Administration of drugs.* Medications shall be administered only in accordance with the instructions of the attending physician. Controlled substances shall be administered only by qualified personnel. The type and amount of the medication, the time and date, and the staff member administering the medication shall be documented in the child's record. (See IAC 620—8.16(204).)

114.12(17) *Self-administration of drugs.* There shall be written policy and procedures relative to self-administration of prescription medications by residents and only when:

a. Medications are prescribed by a physician.

b. The physician agrees that the patient can self-administer the drug.

c. What is taken and when is documented in the record of the child.

This rule is intended to implement Iowa Code section 237.3.

441—114.13(237) Children's rights.

114.13(1) *Policies in writing.* All policies and procedures covered in this rule shall be in writing and provided to the child and parents or guardian upon the child's admission to the facility. The rationale and circumstances of any deviation from these policies shall be discussed with the child's parents or guardian and the referring worker, documented, and placed in the child's case record.

114.13(2) *Confidentiality.* Information regarding children and their families shall be kept confidential and released only with proper written authority.

114.13(3) *Communication.*

a. Visitation shall be allowed with members of the child's immediate family unless otherwise regulated by the court.

b. Visits shall be allowed with other significant persons.

c. Consideration shall be given to privacy for family visits.

d. The child shall be permitted to communicate with legal counsel and the referring worker.

e. The child shall be allowed to conduct private telephone conversations with family members. Incoming calls may be screened by staff to verify the identity of the caller before approval is given.

f. The child shall be allowed to send and receive mail. The facility may require the child to open incoming mail in the presence of a staff member when it is suspected to contain contraband articles, or when there is money that should be receipted and deposited.

g. When limitations on visitation, calls or other communications are indicated, they shall be determined with the participation or knowledge of the child, family or guardian, and the referring worker. All restrictions shall have specific bases which shall be made explicit to the child and family and documented in the child's case record.

114.13(4) *Privacy.* Reasonable provisions shall be made for the privacy of residents.

This rule is intended to implement Iowa Code section 237.2.

441—114.14(237) Personal possessions.

114.14(1) *Belongings.* A facility shall allow a child in care to bring personal belongings and to acquire belongings in accordance with the child's service plan. However, the facility shall, as necessary, limit or supervise the use of these items while the child is in care.

114.14(2) *Clothing.* A facility shall ensure that each child in care has adequate, clean, well-fitting, attractive, and seasonable clothing as required for health, comfort, and physical well-being. The clothes should be appropriate to age, sex and individual needs.

This rule is intended to implement Iowa Code section 237.2.

441—114.15(237) Religion—culture.

114.15(1) *Facility orientation.* A facility shall have a written description of its religious orientation, particular religious practices that are observed, and any religious restrictions. This description shall be provided to the child, the parent(s) or guardian, and the placing agency at the time of admission.

114.15(2) *Child participation.* When a facility accepts a child, the child shall have the opportunity to participate in religious activities and services in accordance with the child's own faith or that of the child's parent(s) or guardian. The facility shall, when necessary and reasonable, arrange transportation for religious activities. Wherever feasible, the child shall be permitted to attend religious activities and services in the community.

This rule is intended to implement Iowa Code section 237.2.

441—114.16(237) Work or vocational experiences.

114.16(1) *Written description.* The facility shall have a written statement of any work and vocational experiences available to children.

114.16(2) *Program component.* Work as part of the program shall be identified in the child's case plan.

114.16(3) *Self-care.* Ordinary self-care and self-sufficiency tasks are not considered work.

114.16(4) *Purpose.* Work shall be in the child's interest, within the child's ability, with payment where appropriate, and never solely in the interest of the facility's goals or needs.

This rule is intended to implement Iowa Code section 237.2.

441—114.17(237) Family involvement. There shall be written policies and procedures for family involvement that shall encourage continued involvement of the family with the child.

This rule is intended to implement Iowa Code section 237.2.

441—114.18(237) Children's money.

114.18(1) *Treatment of funds.* Money earned, received as a gift, or as an allowance by a child in care shall be deemed to be that child's personal property.

114.18(2) *Limitations.* The facility shall have a written policy on limitations on the child's use of funds.

114.18(3) *Records.* The facility shall maintain a separate accounting system for children's money.

This rule is intended to implement Iowa Code section 237.2.

441—114.19(237) Child abuse. Written policies shall prohibit mistreatment, neglect, or abuse of children and specify reporting and enforcement procedures for the facility. Alleged violations shall be reported immediately to the director of the facility and appropriate department of human services personnel. Any employee found to be in violation of Iowa Code chapter 232, division III, part 2, as substantiated by the department of human services' investigation shall be subject to the agency's policies concerning dismissal.

This rule is intended to implement Iowa Code section 237.2.

441—114.20(237) Discipline.

114.20(1) *Generally.* The facility shall have written policies regarding methods used for control and discipline of children which shall be available to all staff and to the child's family. Agency staff shall be in control of and responsible for discipline at all times. Discipline shall not include the withholding of basic necessities such as food, clothing, or sleep.

114.20(2) *Corporal punishment prohibited.* The facility shall have a policy that clearly prohibits staff or the children from utilizing corporal punishment as a method of disciplining or correcting children. This policy is to be communicated, in writing, to all staff of the facility.

114.20(3) *Physical restraint.* The use of physical restraint shall be employed only to prevent the child from injury to self, to others, or to property. Physical restraint must be conducted with the child in a standing position whenever possible.

a. No staff person shall use any restraint that obstructs the airway of a child.

b. Prone restraint is prohibited. Staff persons who find themselves involved in the use of a prone restraint when responding to an emergency must take immediate steps to end the prone restraint.

c. If a staff person physically restrains a child who uses sign language or an augmentative mode of communication as the child's primary mode of communication, the child shall be permitted to have the child's hands free of restraint for brief periods unless the staff person determines that such freedom appears likely to result in harm to the child, others, or property.

d. The rationale and authorization for the use of physical restraint and staff action and procedures carried out to protect the child's rights and to ensure safety shall be clearly set forth in the child's record by the responsible staff persons.

114.20(4) *Other restraints.* Only comprehensive residential facilities may use a control room, locked cottages, mechanical restraints or chemical restraint.

114.20(5) *Behavior expectations.* The facility shall make available to the child and the child's parents or guardian written policies regarding the following areas:

a. The general expectation of behavior including the facility's rules and practices.

b. The range of reasonable consequences that may be used to deal with inappropriate behavior.

This rule is intended to implement Iowa Code section 237.3.

[**ARC 9488B**, IAB 5/4/11, effective 7/1/11]

441—114.21(237) Illness, accident, death, or absence from the facility.

114.21(1) *Notification of illness.* A facility shall notify the child's parent(s), guardian and responsible agency of any serious illness, incident involving serious bodily injury, or circumstances causing removal of the child from the facility.

114.21(2) *Notification of death.* In the event of the death of a child, a facility shall notify immediately the physician, the child's parent(s) or guardian, the placing agency, and the appropriate state authority. The agency shall cooperate in arrangements made for examination, autopsy, and burial.

This rule is intended to implement Iowa Code section 237.2.

441—114.22(237) Records. In the event of closure of a facility, children's records shall be sent to the department of human services for retention according to the records retention policy.

This rule is intended to implement Iowa Code section 237.2.

441—114.23(237) Unannounced visits.

114.23(1) *Time.* The unannounced visit shall occur during periods of the day when the child would normally be in the facility and awake. Visits at other times may occur only as a result of a specific complaint.

114.23(2) *Observations.* The visit shall include an assessment of the following areas:

a. Interaction between the staff and child.

b. Interaction between the children.

c. Discussion with the child about experiences in the facility.

d. A check on any previously sighted deficiencies.

e. Overall impression of the facility.

114.23(3) *Recommendation.* The licensing staff shall recommend follow-up, when needed.

This rule is intended to implement Iowa Code section 237.7.

441—114.24(237) Standards for private juvenile shelter care and detention homes. The standards of 441—Chapter 105 shall be used as the basis for licensing private juvenile shelter care and detention homes. These homes are not required to meet other standards of 441—Chapter 114.

This rule is intended to implement Iowa Code section 237.3.

[Filed 8/27/81, Notice 7/8/81—published 9/16/81, effective 11/1/81]
[Filed 2/26/82, Notice 10/28/81—published 3/17/82, effective 5/1/82]
[Filed 12/17/82, Notice 10/13/82—published 1/5/83, effective 2/9/83]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]
[Filed emergency 2/16/95 after Notice 12/7/94—published 3/15/95, effective 2/16/95]
[Filed 10/15/97, Notice 7/30/97—published 11/5/97, effective 1/1/98]
[Filed 3/8/00, Notice 1/26/00—published 4/5/00, effective 6/1/00]
[Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]
[Filed ARC 9488B (Notice ARC 9368B, IAB 2/9/11), IAB 5/4/11, effective 7/1/11]
[Filed ARC 2743C (Notice ARC 2652C, IAB 8/3/16), IAB 10/12/16, effective 12/1/16]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

CHAPTER 116
LICENSING AND REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN WITH AN INTELLECTUAL DISABILITY

[Prior to 7/1/83, Social Services[770] Ch 116]
[Prior to 2/11/87, Human Services[498]]

441—116.1(237) Applicability. This chapter relates specifically to the licensing and regulation of residential facilities serving children with an intellectual disability. Refer to 441—Chapter 112 for basic licensing and regulation of all foster care facilities, 441—Chapter 114 for definitions and minimum standards for all group living foster care facilities, including community care facilities, and 441—Chapter 115 for definitions and standards for comprehensive residential facilities for children. Chapters 112 and 114 apply to community residential facilities for children with an intellectual disability and Chapters 112, 114 and 115 apply to comprehensive residential facilities for children with an intellectual disability with the exception of the areas discussed specifically in this chapter.

This rule is intended to implement Iowa Code chapter 237.

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—116.2(237) Definitions.

"Community residential facility for children with an intellectual disability" means a community residential facility as defined in rule 441—114.2(237) which serves children with an intellectual disability as defined in Iowa Code chapter 222.

"Comprehensive residential facility for children with an intellectual disability" means a comprehensive residential facility as defined in rule 441—115.2(237) which serves children with an intellectual disability as defined in Iowa Code chapter 222.

"Direct-service provider" means any employee of an agency whose primary responsibility is the care and programming of the children through direct interactions. The definition of "child care worker" in rule 441—114.2(237) and all other references to child care workers shall be replaced by this definition and the term "direct-service providers" when reading the other applicable rule chapters.

"Indirect-service provider" means an employee of an agency who supervises, coordinates and administers employees and program components. The definitions of "caseworker" and "casework supervisor" in rule 441—114.2(237) and all other references to caseworkers or casework supervisors shall be replaced by this definition and the term "indirect-service providers" when reading the other applicable rule chapters.

This rule is intended to implement Iowa Code section 237.1.

[**ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—116.3(237) Qualifications of staff.

116.3(1) *Direct-service providers.* Direct-service providers shall be paraprofessionals or professionals meeting all of the following criteria:

a. Paraprofessionals shall:

(1) Be at least 18 years of age.

(2) Have graduated from high school or earned a high school equivalency degree.

(3) Have completed the prescribed agency training program.

(4) Be appropriate to the specific job description of the employing agency.

b. Professionals in the direct-service provider category shall:

(1) Be at least 18 years of age.

(2) Have a bachelor of arts degree in a related field; or an associate of arts degree in a related field and two years experience specific to the job responsibilities; or two years of higher education in a related field and two years' experience specific to job responsibilities; or four years' experience in programming specific to job responsibilities.

(3) Have completed the prescribed agency training program.

(4) Be appropriate to the specific job description of the employing agency.

116.3(2) *Indirect-service providers.* Indirect-service providers shall meet one of the following education and experience criteria:

a. Have a master's in social work or a master of arts degree in a related field and one year of experience specific to job responsibilities.

b. Have a bachelor of arts degree in a related field and two years' experience specific to job responsibilities.

c. Have an associate of arts degree in a related field and four years' experience specific to job responsibilities.

d. Have five years' specific treatment program experience relating to the job responsibilities.

This rule is intended to implement Iowa Code section 237.3.

441—116.4(237) Staff to client ratio. The number and qualifications of the staff will vary depending on the needs of the children. There shall be at least a one to four staff to client ratio during prime programming time.

This rule is intended to implement Iowa Code section 237.3.

441—116.5(237) Program components. In addition to the requirements of 441—subrule 114.8(3), the facility shall define in writing who is responsible for overseeing personal hygiene of children and maintaining general orderliness of the facility.

This rule is intended to implement Iowa Code section 237.3.

441—116.6(237) Restraint. In addition to the provisions of 441—Chapters 114 and 115, a restraint may be used as stated in the child's individual care plan as approved by the parent or guardian, caseworker, and facility as long as that facility meets the standards for utilizing that particular type of restraint.

This rule is intended to implement Iowa Code section 237.4.

[Filed 8/27/81, Notice 7/8/81—published 9/16/81, effective 11/1/81]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 2/21/86, after Notice 1/1/86—published 3/12/86, effective 3/1/86]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

CHAPTER 117
FOSTER PARENT TRAINING

PREAMBLE

These rules describe required foster parent orientation, preservice training and in-service training. Their purpose is to ensure that the training and orientation are effective in preparing foster parents for their role.

These rules also describe the standards for training and orientation and the procedure to be approved as a training provider.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.1(237) Required preservice training. Foster parent preservice training shall be offered by the department or by a licensed child-placing agency through a training program that has been approved by the department pursuant to rule 441—117.5(237).

117.1(1) *Preservice training requirement.* Each individual foster parent applicant shall complete the entire 30-hour preservice training as approved by the foster family program manager.

a. Applicants shall complete the 30-hour preservice training before receiving a license for the first time.

b. Applicants shall retake the 30-hour preservice training if they do not complete the curriculum within 24 months after initially commencing it.

c. The department may waive the preservice training requirement in whole or in part when the department finds that:

(1) The applicant has completed relevant training or has a combination of relevant training and experience that is an acceptable equivalent to all or a portion of the required preservice training; or

(2) There is good cause for the waiver based upon the circumstances of the child and the applicant.

117.1(2) *Preservice training program approval requirements.*

a. *Content.* The program shall be designed to assist prospective foster parents in developing the understanding and abilities that are essential to promote children's safety, permanence, and well-being. The program shall address the following topics:

(1) Children in foster care, their needs and rights.

(2) Families of children in foster care, their rights and responsibilities.

(3) Caseworkers and their role.

(4) Foster parents, their motivation and role.

(5) Self-assessment of foster parent's strengths.

(6) The team effort of foster parents and caseworkers.

(7) The impact of foster care placement on the child, the child's family and the foster family.

(8) The purpose and importance of the child's contact with the child's family.

(9) Training in communication and behavior management.

(10) Permanency planning.

(11) The reasons for placement termination and feelings involved.

b. *Length.* The entire preservice training program shall total at least 30 hours of contact between leaders and participants. The department's recruitment and retention contractor shall devise a procedure for applicants to make up any portions of the preservice training that are missed.

c. *Instructors.* The program shall be team taught by at least one foster or adoptive parent and one casework staff person. All instructors shall be certified leaders or as approved by the adult, children and family services division administrator or designee.

d. *Group method.* The program shall be provided in groups that consist of six or more persons. The training shall be offered to a foster family individually only when the foster family is unable to attend group training for reasons such as serious medical conditions, as approved by the social work administrator or designee.

e. *Training certificate.* A certificate of completion shall be provided to each foster parent who completes the training.

f. *Training evaluation.* A means for participants in the training to evaluate the instructors and the content shall be provided.

g. *Training records.* A record of the applicants who begin and complete the training and of the training program evaluations shall be submitted to the recruitment and retention contractor at the end of each 30-hour preservice training session.

117.1(3) *Universal precautions.* Before licensure, each individual foster parent shall complete one hour of training related to the use and practice of universal precautions. Training shall be completed through the approved individual self-study course, "Universal Precautions in Foster and Adoptive Resource Family Homes."

117.1(4) *Additional preservice training.* Before licensure, each foster parent shall complete training in an agency-approved medication management course, cardiopulmonary resuscitation (CPR), first aid, the reasonable and prudent parent standard, and the mandatory reporter training on child abuse identification.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 1808C**, IAB 1/7/15, effective 3/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—117.2(237) Required orientation. All foster parent applicants shall attend orientation before attending the 30-hour preservice training and before a foster child is placed in their home. Orientation shall not count toward the required 30 hours of preservice training.

117.2(1) *Method of provision.* The recruitment and retention contractor may provide orientation:

a. In an individual meeting with one set of foster parent applicants; or

b. In a group setting.

117.2(2) *Provider.* Orientation shall be provided by the recruitment and retention contractor completing the family's licensing study.

117.2(3) *Content.* Orientation shall be designed to provide the foster parent applicant with information on the policies and procedures of the foster care and adoption programs and shall include the following:

a. Process and procedures for placement and termination of placement.

b. Medical assistance program information.

c. Foster family reimbursement information and adoption subsidy information if applicable.

d. Child abuse law and child abuse investigation procedures.

e. Confidentiality.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 1808C**, IAB 1/7/15, effective 3/1/15]

441—117.3(237) Application materials for in-service training. Applications for approval of an in-service training program shall be submitted on Form 470-2541, Foster Parent Training Application, and must be approved before the delivery of the training. Applications submitted after a training is completed shall not be approved.

117.3(1) Except for cardiopulmonary resuscitation and first-aid training, foster parent in-service training shall meet the requirements in rule 441—117.7(237).

117.3(2) Applications shall be submitted with the following materials:

a. A detailed training program description relative to a foster parent, including objectives, program agenda, content, participant materials, and time frames.

b. Names of program instructors and their qualifications to provide the training.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.4(237) Application process for in-service training.

117.4(1) *Group training.* Applications to provide group foster parent training shall be submitted to the department office for the service area in which the training will be conducted.

117.4(2) *Individual training.* Applications for approval for individual training, college credit, written materials, DVDs or videotapes shall be submitted to the department office for the service area in which the foster family resides.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.5(237) Application decisions. The department shall notify the applicant of its decision regarding the application for approval of in-service training within 30 days of receipt of the training materials described in rule 441—117.3(237). This notification shall include the reason for not giving approval if approval is denied.

117.5(1) *Approval.* Foster parent training programs which meet the criteria in rule 441—117.1(237) or in rule 441—117.7(237) and which are submitted pursuant to rules 441—117.3(237) and 441—117.4(237) shall be approved by the department. In-service training completed before the program has received department approval shall not count toward the required six credit hours of in-service training. In-service training approvals are valid for one year.

117.5(2) Rescinded IAB 8/9/89, effective 10/1/89.

117.5(3) *Denial.* Preservice training programs which do not meet the requirements in rules 441—117.1(237), 117.3(237), and 117.4(237) and in-service training programs which do not meet the criteria in rules 441—117.3(237), 117.4(237) and 117.7(237) shall be denied approval. The applicant may submit a revised program for approval at a later date.

117.5(4) *Revocation.* Approval shall be revoked when any of the following exist and corrective action is not taken to correct the deficiencies within 45 days.

a. The training provider fails to provide the training as described in the approved application materials.

b. Over 25 percent of the participant evaluations of the training program rate the training program as not helpful.

If approval is revoked, the training provider may submit a revised program at a later date.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.6(237) Application conference available. If an applicant or provider of training objects in writing within seven days after the notification of the department's decision to deny approval, the area social work administrator shall review the decision to determine if the original decision shall stand. The decision of the area social work administrator is final and is not subject to appeal.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—117.7(237) Required in-service training. At least six hours of in-service training are required to assist foster parents in confidently and effectively addressing the needs of children placed in foster care. The Foster Parent Training Plan, Form 470-3341, shall be used to address in-service training needs. The training plan shall be developed with the department or retention and recruitment contractor and the foster parent annually.

117.7(1) *Providers of in-service training.* Foster parent in-service training may be provided by the department, a licensed child-placing or child-caring agency, or an agency, institution, or association with expertise in the training content. Agencies, institutions, or associations wishing to have a foster parent in-service training program or workshop approved shall submit application materials pursuant to rules 441—117.3(237) and 441—117.4(237).

117.7(2) *In-service training program approval requirements.*

a. *Content.* The program shall relate to the foster parent's role in providing foster care and the skills needed by a foster parent. Training shall be specific to developing each foster parent's skills for addressing the needs of foster children.

b. *Method.* The training shall be provided through one or more of the following methods:

(1) Face-to-face training to a group.

(2) Face-to-face training to an individual foster family.

(3) Written materials.

(4) DVDs or videotapes.

(5) Internet training classes offered through the Iowa Foster and Adoptive Parents Association (IFAPA).

(6) Internet training classes offered through www.fosterparents.com, except for cardiopulmonary resuscitation and first-aid trainings, which are not approved.

c. *Credit hours.* Credit hours for approved training shall be as follows:

(1) Group training shall receive one credit hour for each face-to-face contact hour.

(2) Written materials shall receive one credit hour for each 100 pages.

(3) DVDs or videotapes shall receive one credit hour for each two program hours.

(4) College courses shall receive one credit hour for each college credit hour.

(5) Internet training classes shall receive one credit hour for each program hour. A maximum of three hours of training credit per year may be earned through the Web site www.fosterparents.com.

d. Approved training. The following training programs shall be considered as meeting the in-service training requirements:

(1) Workshops offered at the Iowa Association of Foster and Adoptive Parents' annual state conference.

(2) Workshops offered at the National Foster Parent Association's annual conference.

(3) Rescinded IAB 8/9/89, effective 10/1/89.

117.7(3) *Foster parent training requirements.* Each individual foster parent shall complete six credit hours of department-approved in-service training annually when the foster parent has an approved one-year license or an approved two-year license.

a. Renewal license. For a one-year license renewal, each foster parent shall complete six hours of annual in-service training within the 12-month period beginning on the effective date of the foster parent's renewal license. For a two-year license renewal, each foster parent shall complete six hours of in-service training within the 12 months of the first license year beginning on the effective date of the two-year license renewal. For the second year of a two-year license renewal, each foster parent shall complete six hours of in-service training within the 12 months of the second year of the two-year license renewal.

b. Content. The choice of in-service training shall be based upon an assessment of the foster parent's training needs made by the foster parent and the recruitment and retention contractor in collaboration with the department licensing worker.

(1) Each foster parent must complete the specific training required in rule 441—117.8(237).

(2) At least three credit hours of the annual six hours of in-service training shall be group training.

(3) Except for the mandatory reporter training on child abuse identification class, training credit will not be allowed for any in-service training class that is repeated unless the class has been updated with new information.

c. Documentation. Each individual foster parent shall submit Form 470-2540, Foster Parent Training Report, to the recruitment and retention contractor within 30 days after completion of each in-service training.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—117.8(237) Specific in-service training required.

117.8(1) *Cardiopulmonary resuscitation (CPR).* All foster parents shall maintain their CPR certification and a certificate or card indicating the date of training and expiration. The training shall be provided by:

a. A nationally recognized training organization, such as the American Red Cross, the American Heart Association, the National Safety Council, or Emergency Medical Planning (Medic First Aid), or

b. An equivalent certified trainer and curriculum approved by the department.

117.8(2) *First aid.* All foster parents shall be certified in first aid at least every three years and shall maintain their first-aid certification and a certificate or card indicating the date of training and expiration.

117.8(3) *Child abuse reporting.* Each foster parent shall complete an approved mandatory child abuse reporter training every five years after the foster parent's initial preservice mandatory child abuse reporter training relating to the identification of child abuse and the requirements and procedures for the reporting of child abuse pursuant to Iowa Code section 232.68.

a. Training provider. The foster parent shall be responsible for obtaining the required two-hour mandatory reporter training on child abuse identification and reporting as approved by the Iowa department of public health. A list of approved training opportunities is available on the Iowa department of public health Web site by searching "mandatory reporter training."

b. Documentation. The foster parent shall secure documentation of the training content, amount, and provider and shall forward the documentation to the recruitment and retention contractor, who will provide the documentation to the department for inclusion in the foster parent's licensing file.

117.8(4) *Caring for children with HIV.* Before placement of an HIV-infected child occurs, the foster parents shall complete the course "Caring for Children With HIV" or an approved alternative course that contains information on the unique aspects of pediatric HIV disease, transmission and infection control, the spectrum of HIV disease, confidentiality, death and bereavement, and self-care for the caregiver.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—117.9(237) Foster parent training expenses. No expense stipend is provided for orientation or preservice training.

117.9(1) *Training stipend.* Each family that is issued an initial or renewal foster family home license shall receive a $100 stipend to be used for the family's annual in-service training. The department's recruitment and retention contractor shall issue one stipend per license on or after the date that the license is issued. When a family with a two-year foster family home license has completed the first training cycle of six hours of in-service training, the contractor shall issue the next training stipend no earlier than the start of the second year of licensure contingent upon the foster family's completion of the in-service training hours in the first cycle. Foster families who elect not to receive the $100 stipend shall notify the department.

117.9(2) *Trainer fees.* Foster parents and social workers who serve as trainers for approved preservice training programs shall each be paid a contract fee per class hour appropriate to community standards based upon the education and experience of each trainer. These rates shall be negotiated between the recruitment and retention contractor and the trainer.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 0356C**, IAB 10/3/12, effective 12/1/12]

These rules are intended to implement Iowa Code section 237.5A.

[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]
[Filed 7/13/89, Notice 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 11/18/02, Notice 8/21/02—published 12/11/02, effective 2/1/03]
[Filed ARC 8010B (Notice ARC 7712B, IAB 4/8/09), IAB 7/29/09, effective 10/1/09]
[Filed ARC 0356C (Notice ARC 0202C, IAB 7/11/12), IAB 10/3/12, effective 12/1/12]
[Filed ARC 1808C (Notice ARC 1706C, IAB 10/29/14), IAB 1/7/15, effective 3/1/15]
[Filed ARC 2069C (Notice ARC 1997C, IAB 5/27/15), IAB 8/5/15, effective 10/1/15]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

CHAPTER 142
INTERSTATE COMPACT ON THE PLACEMENT OF CHILDREN

[Prior to 7/1/83, Social Services[770] Ch 142]
[Prior to 2/11/87, Human Services[498]]

441—142.1(232) Compact agreement. As a member of the interstate compact on placement of children, the department of human services shall cooperate on interstate aspects of placements preliminary to possible adoptions, placements in foster care where no adoption is contemplated, placements with any parent or relative, and institutional placements of adjudicated children in need of assistance needing special services or programs not available within the state. Any public or private agency instrumental in placement of a child in Iowa or from Iowa and in such public or private agency's custody shall go through the interstate compact on placement of children.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.2(232) Compact administrator.

142.2(1) The compact administrator may appoint up to three deputy compact administrators to serve as active members of the association of the interstate compact on the placement of children and who shall be responsible for day-to-day operation of the interstate compact.

142.2(2) The compact administrator shall be responsible for the administration of the compact between the compact administrator's state and other contracting states.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.3(232) Article II(d). For the purposes of article II(d), a child caring agency or institution shall not include any institution caring for the mentally ill, mentally defective or epileptic; or any institution primarily educational in character; or any hospital or other medical facility.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.4(232) Article III(a). For the purposes of article III(a), "sending state" shall mean "sending agency".
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.5(232) Article III(a) procedures.

142.5(1) All intended placements in Iowa or from Iowa coming under the purview of this compact shall be referred to the interstate compact unit, bureau of adult, children and family services, department of human services.

142.5(2) All persons involved in the placement of a child into Iowa or from Iowa into another state shall meet all the placement requirements of the receiving state prior to the actual placement.

142.5(3) Supervision of placements made by persons or agencies outside of Iowa shall be provided by a licensed Iowa agency, the department of human services, or an Iowa certified adoption investigator. Exempted from this provision are:

a. Any agency licensed as a child-placing agency in another state which has its principal place of business in a county directly adjacent to an Iowa border may practice in the Iowa counties contiguous to the out-of-state county.

b. Placement in a facility for treatment that is licensed by the department unless the department specifies that the supervision must be provided by the department for all placements in any particular facility.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.6(232) Article III(c). A child may be placed in Iowa preliminary to adoption only when:

142.6(1) Rescinded by Governor's Administrative Rules Executive Order No. 3, 11/6/79.

142.6(2) There has been a preplacement investigation by an authorized person or agency in Iowa, such investigation has been made available to the Iowa interstate compact unit, the investigation has been made within the past year, and the sending state intending to place the child has been notified that the home has been approved for an adoptive placement in Iowa.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.7(232) Article VIII(a). For the purpose of article VIII(a), relative shall mean stepparent, grandparent, adult brother or sister, or adult uncle or aunt, and guardian shall mean any guardian other than that appointed as preliminary to adoption.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.8(232) Applicability. The requirements of this compact shall be in effect for all placements into Iowa from any state or from Iowa to any state within the United States and the District of Columbia.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

441—142.9(232) NEICE database.

142.9(1) *Definitions.* For the purpose of this chapter, unless the context otherwise requires:

"National Electronic Interstate Compact Enterprise system" or *"NEICE system"* means the national electronic web-based system for administration of the interstate compact on the placement of children made available to states by the American Public Human Services Association through its affiliate, the Association of Administrators of the Interstate Compact on the Placement of Children.

"Security requirements" means all policies or system security guidance established by the department and the office of the chief information officer related to the use of external computer systems for the storage of personally identifiable data elements of applicants for and recipients of department services. Security requirements as defined herein include but are not necessarily limited to completion by the vendor of the then current cybersecurity framework made available by the National Institute of Standards and Technology, department confirmation that the system has passed the cybersecurity framework analysis, completion by the vendor of an information security risk assessment acceptable to the department, performance by the vendor of a system penetration test acceptable to the department, and an application scan for vulnerabilities, as well as remediation of any vulnerabilities identified.

142.9(2) *Department obligation to provide data to the NEICE system.*

a. At all times that the NEICE system meets security requirements, the department shall place in the system all data elements and information that the system is configured to accept concerning children subject to the interstate compact.

b. Prior to placing personally identifiable data elements in the NEICE system, the department shall confirm that the NEICE system complies with all security requirements. If at any time after placement of personally identifiable data in the NEICE system the department determines that the NEICE system fails to meet all security requirements or that personally identifiable data placed in the system by the department has been used or disclosed inappropriately, the department may cease using the NEICE system and may demand that all data provided by the department be removed from the system.

These rules are intended to implement Iowa Code chapter 232, division IX.
[**ARC 3186C**, IAB 7/5/17, effective 8/15/17]

[Filed 4/30/76, Notice 3/22/76—published 5/17/76, effective 6/21/76]
[Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79[1]]
[Subrule 142.6(1) rescinded by Governor's Administrative Rules Executive Order No. 3, 11/6/79—published 11/28/79]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed ARC 3186C (Notice ARC 3020C, IAB 4/12/17), IAB 7/5/17, effective 8/15/17]

[1] Effective date of subrule 770—142.6(1) delayed by the Administrative Rules Review Committee 70 days.

CHAPTER 156
PAYMENTS FOR FOSTER CARE

[Prior to 7/1/83, Social Services[770] Ch 137]
[Previously appeared as Ch 137—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—156.1(234) Definitions.

"Child welfare services" means age-appropriate activities to maintain a child's connection to the child's family and community, to promote reunification or other permanent placement, and to facilitate a child's transition to adulthood.

"Cost of foster care" means the maintenance and supervision costs of foster family care, the maintenance costs and child welfare service costs of group care, and the maintenance and service costs of supervised apartment living and shelter care. The cost for foster family care supervision and for supervised apartment living services provided directly by the department caseworker shall be $250 per month. When using this average monthly charge results in unearned income or parental liability being collected in excess of the cost of foster care, the excess funds shall be placed in the child's escrow account. The cost for supervised apartment living services purchased from a private provider shall be the actual costs paid by the department.

"Department" means the Iowa department of human services and includes the local offices of the department.

"Director" means the director of the department of human services or the director's designee.

"Earned income" means income in the form of a salary, wages, tips, bonuses, commissions earned as an employee, income from job corps or profit from self-employment.

"Escrow account" means an interest bearing account in a bank or savings and loan association that is maintained by the department in the name of a particular child.

"Family foster care supervision" means the support, assistance, and oversight provided by department caseworkers to children in family foster care and directed toward achievement of the child's permanency plan goals.

"Foster care" means substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision and health care.

"Foster family care" means foster care provided by a foster family licensed by the department according to 441—Chapter 113 or licensed or approved by the placing state. The care includes the provision of food, lodging, clothing, transportation, recreation, and training that is appropriate for the child's age and mental and physical capacity.

"Group care maintenance" means food, clothing, shelter, school supplies, personal incidentals, daily care, general parenting, discipline, and supervision of children to ensure their well-being and safety, and administration of maintenance items provided in a group care facility.

"Income" means earned and unearned income.

"Inflation factor" means the amount by which the consumer price index for all urban consumers increased during the calendar year ending December 31 that preceded the contractor's fiscal year end.

"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 has at least one year of experience working with persons with an intellectual disability.

"Mental health professional" means a person who meets all of the following conditions:

1. Holds at least a master's degree in a mental health field including, but not limited to, psychology, counseling and guidance, psychiatric nursing and social work; or is a doctor of medicine or osteopathic medicine; and

2. Holds a current Iowa license when required by the Iowa professional licensure laws (such as a psychiatrist, a psychologist, a marital and family therapist, a mental health counselor, an advanced registered nurse practitioner, a psychiatric nurse, or a social worker); and

3. Has at least two years of postdegree experience supervised by a mental health professional in assessing mental health problems, mental illness, and service needs and in providing mental health services.

"Parent" means the biological or adoptive parent of the child.

"Parental liability" means a parent's liability for the support of a child during the period of foster care placement. Liability shall be determined pursuant to 441—Chapter 99, Division I.

"Physician" means a licensed medical or osteopathic doctor as defined in Iowa Code section 135.1(4).

"Prevailing rate" means the maximum combined service and maintenance reimbursement rate the department pays to contracted shelter care providers as authorized by the legislature.

"Provider" means the entity that has executed a contract with the department to provide services.

"Service area manager" means the department employee or designee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Special needs child" means a child with needs for emotional care, behavioral care, or physical and personal care that require additional skills, knowledge, or responsibility on the part of the foster parents, as measured by Form 470-4401, Foster Child Behavioral Assessment. See subrule 156.6(4).

"Unearned income" means any income that is not earned income and includes supplemental security income (SSI) and other funds available to a child residing in a foster care placement.

This rule is intended to implement Iowa Code section 234.39.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2885C**, IAB 1/4/17, effective 3/1/17]

441—156.2(234) Foster care recovery. The department shall recover the cost of foster care provided by the department pursuant to the rules in this chapter and the rules in 441—Chapter 99, Division I, which establishes policies and procedures for the computation and collection of parental liability.

156.2(1) Funds shall be applied to the cost of foster care in the following order and each source exhausted before utilizing the next funding source:

a. Unearned income of the child.

b. Parental liability of the noncustodial parent.

c. Parental liability of custodial parent(s).

156.2(2) The department shall serve as payee to receive the child's unearned income. When a parent or guardian is not available or is unwilling to do so, the department shall be responsible for applying for benefits on behalf of a child placed in the care of the department. Until the department becomes payee, the payee shall forward benefits to the department. For voluntary foster care placements of children aged 18 and over, the child is the payee for the unearned income. The child shall forward these benefits, up to the actual cost of foster care, to the department.

156.2(3) The custodial parent shall assign child support payments to the department.

156.2(4) Unearned income of a child and parental liability of the noncustodial parent shall be placed in an account from whence it shall be applied toward the cost of the child's current foster care and the remainder placed in an escrow account.

156.2(5) When a child has funds in escrow these funds may be used by the department to meet the current needs of the child not covered by the foster care payments and not prohibited by the source of the funds.

156.2(6) When the child leaves foster care, funds in escrow shall be paid to the custodial parent(s) or guardian or to the child when the child has attained the age of majority, unless a guardian has been appointed.

156.2(7) When a child who has unearned income returns home after the first day of a month, the remaining portion of the unearned income (based on the number of days in the particular month) shall

be made available to the child and the child's parents, guardian or custodian, if the child is eligible for the unearned income while in the home of a parent, guardian or custodian.

This rule is intended to implement Iowa Code section 234.39.

441—156.3(252C) Computation and assessment of parental liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.4(252C) Redetermination of liability. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.5(252C) Voluntary payment. Rescinded IAB 3/13/96, effective 5/1/96.

441—156.6(234) Rate of maintenance payment for foster family care.

156.6(1) *Basic rate.* A monthly payment for care in a foster family home licensed in Iowa shall be made to the foster family based on the following schedule:

Age of child	Daily rate
0 through 5	$16.78
6 through 11	$17.45
12 through 15	$19.10
16 or over	$19.35

156.6(2) *Out-of-state rate.* A monthly payment for care in a foster family home licensed or approved in another state shall be made to the foster family based on the rate schedule in effect in Iowa, except that the service area manager or designee may authorize a payment to the foster family at the rate in effect in the other state if the child's family lives in that state and the goal is to reunite the child with the family.

156.6(3) *Mother and child in foster care.* When the child in foster care is a mother whose young child is in placement with her, the rate paid to the foster family shall be based on the daily rate for the mother according to the rate schedule in subrules 156.6(1) and 156.6(4) and for the child according to the rate schedule in subrule 156.6(1). The foster parents shall provide a portion of the young child's rate to the mother to meet the partial maintenance needs of the young child as defined in the case permanency plan.

156.6(4) *Difficulty of care payment.*

a. For placements made before January 1, 2007, when foster parents provide care to a special needs child, the foster family shall be paid the basic maintenance rate plus $5 per day for extra expenses associated with the child's special needs. This rate shall continue for the duration of the placement.

b. When a foster family provides care to a sibling group of three or more children, an additional payment of $1 per day per child may be authorized for each nonspecial needs child in the sibling group.

c. When the foster family's responsibilities in the case permanency plan include providing transportation related to family or preplacement visits outside the community in which the foster family lives, the department worker may authorize an additional maintenance payment of $1 per day. Expenses over the monthly amount may be reimbursed with prior approval by the worker. Eligible expenses shall include the actual cost of the most reasonable passenger fare or gas.

d. Effective January 1, 2007, when a foster family provides care to a child who was receiving behavioral management services for children in therapeutic foster care in that placement as of October 31, 2006, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

e. Effective January 1, 2007, when a service area manager determines that as of October 31, 2006, a foster family was providing care for a child comparable to behavioral management services for children in therapeutic foster care, except that the placement is supervised by the department and the child's treatment plan is supervised by a physician, a mental health professional, or an intellectual disabilities professional, the foster family shall be paid the basic maintenance rate plus $15 per day for that child. This rate shall continue for the duration of the placement.

f. For placements made on or after January 1, 2007, the supervisor may approve an additional maintenance payment above the basic rate in subrule 156.6(1) to meet the child's special needs as identified by the child's score on Form 470-4401, Foster Child Behavioral Assessment. The placement worker shall complete Form 470-4401 within 30 days of the child's initial entry into foster care.

(1) Additional maintenance payments made under this paragraph shall begin no earlier than the first day of the month following the month in which Form 470-4401 is completed and shall be awarded as follows:

1. Behavioral needs rated at level 1 qualify for a payment of $4.81 per day.
2. Behavioral needs rated at level 2 qualify for a payment of $9.62 per day.
3. Behavioral needs rated at level 3 qualify for a payment of $14.44 per day.

(2) The department shall review the child's need for this difficulty of care maintenance payment using Form 470-4401:

1. Whenever the child's behavior changes significantly;
2. When the child's placement changes;
3. After termination of parental rights, in preparation for negotiating an adoption subsidy or pre-subsidy payment; and
4. Before a court hearing on guardianship subsidy.

g. All maintenance payments, including difficulty of care payments, shall be documented on Form 470-0716, Foster Family Placement Contract.

h. Rescinded IAB 1/3/07, effective 1/1/07.

156.6(5) *Payment method.* All foster family maintenance payments shall be made directly to the foster family.

156.6(6) *Return of overpayments.* When a foster family has received payments in excess of those allowed under this chapter, the department caseworker shall ask the foster family to return the overpayment. If the foster family is returning the overpayment to the department, the caseworker will note the monthly amount the foster family agrees to pay in the family's case file. The amount returned shall not be less than $50 per month.

This rule is intended to implement Iowa Code section 234.38 and 2013 Iowa Acts, Senate File 446, sections 18 and 19.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 8904B**, IAB 6/30/10, effective 7/1/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 0240C**, IAB 8/8/12, effective 7/11/12; **ARC 0419C**, IAB 10/31/12, effective 12/5/12; **ARC 0858C**, IAB 7/24/13, effective 7/1/13; **ARC 1061C**, IAB 10/2/13, effective 11/6/13; **ARC 2885C**, IAB 1/4/17, effective 3/1/17]

441—156.7(234) Purchase of family foster care services. Rescinded IAB 5/6/09, effective 7/1/09.

441—156.8(234) Additional payments.

156.8(1) *Clothing allowance.* When, in the judgment of the worker, clothing is needed at the time the child is removed from the child's home and placed in foster care, an allowance may be authorized, not to exceed $237.50, to purchase clothing.

a. Once during each calendar year that the child remains in foster care, the department worker may authorize another clothing allowance, not to exceed $190 for family foster care and $100 for all other levels when:

(1) The child needs clothing to replace lost clothing or because of growth or weight change, and

(2) The child does not have escrow funds to cover the cost.

b. When clothing is purchased by the foster family, the foster family shall submit receipts to the worker within 30 days of purchase for auditing purposes, using Form 470-1952, Foster Care Clothing Allowance.

156.8(2) *Supervised apartment living.* Effective July 1, 2013, when a child is initially placed in supervised apartment living, the service area manager or designee may authorize an allowance not to exceed $630 if the child does not have sufficient resources to cover initial costs.

156.8(3) *Medical care.* When a child in foster care needs medical care or examinations which are not covered by the Medicaid program and no other source of payment is available, the cost may be paid from

foster care funds with the approval of the service area manager or designee. Eligible costs shall include emergency room care, medical treatment by out-of-state providers who refuse to participate in the Iowa Medicaid program, and excessive expenses for nonprescription drugs or supplies. Requests for payment for out-of-state medical treatment and for nonprescription drugs or supplies shall be approved prior to the care being provided or the drugs or supplies purchased. Claims shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the service is provided. The rate of payment shall be the same as allowed under the Iowa Medicaid program.

156.8(4) *Transportation for medical care.* When a child in foster family care has expenses for transportation to receive medical care which cannot be covered by the Medicaid program, the expenses may be paid from foster care funds, with the approval of the service area manager. The claim for all the expenses shall be submitted to the department on Form GAX, General Accounting Expenditure, within 90 days after the trip. This payment shall not duplicate or supplement payment through the Medicaid program. The expenses may include the actual cost of meals, parking, child care, lodging, passenger fare, or mileage at the rate granted state employees.

156.8(5) *Funeral expense.* When a child under the guardianship of the department dies, the department will pay funeral expenses not covered by the child's resources, insurance or other death benefits, the child's legal parents, or the child's county of legal settlement, not to exceed $650.

The total cost of the funeral and the goods and services included in the total cost shall be the same as defined in rule 441—56.3(239,249).

The claim shall be submitted by the funeral director to the department on Form GAX, General Accounting Expenditure, and shall be approved by the service area manager. Claims shall be submitted within 90 days after the child's death.

156.8(6) *School fees.* Payment for required school fees of a child in foster family care or supervised apartment living that exceed $5 may be authorized by the department worker in an amount not to exceed $50 per calendar year if the child does not have sufficient escrow funds to cover the cost. Required school fees shall include:

a. Fees required for participation in school or extracurricular activities; and

b. Fees related to enrolling a child in preschool when a mental health professional or an intellectual disabilities professional has recommended school attendance.

156.8(7) *Respite care.* Respite care for a child in family foster care shall be for up to 24 days per calendar year per placement. Except for a certified respite provider, respite shall be provided by a licensed foster family. The payment rate to the respite foster family shall be the rate authorized under rule 441—156.6(234) to meet the needs of the child. Certified respite providers deliver foster child respite services in the foster family home for at least five hours a day at $20 per day.

156.8(8) *Tangible goods, child care, and ancillary services.* To the extent that a foster child's escrow funds are not available, the service area manager or designee may authorize reimbursement to foster parents for the following:

a. Tangible goods for a special needs child including, but not limited to, building modifications, medical equipment not covered by Medicaid, specialized educational materials not covered by educational funds, and communication devices not covered by Medicaid.

b. Child care services when the foster parents are working, the child is not in school, and the provision of child care is identified in the child's case permanency plan.

(1) Child care services shall be provided by a licensed foster parent or a licensed or registered child care provider when available.

(2) When foster parents elect to become child care providers, they shall be registered pursuant to 441—Chapter 110.

c. Ancillary services needed by the foster parent to meet the needs of a special needs child including, but not limited to, specialized classes when directed by the case permanency plan.

d. Ancillary services needed by the special needs child including, but not limited to, recreation fees, in-home tutoring and specialized classes not covered by education funds.

e. Requests for tangible goods, child care, and ancillary services shall be submitted to the service area manager for approval on Form 470-3056, Request for Tangible Goods, Child Care, and Ancillary

Services. Payment rates for tangible goods and ancillary services shall be comparable to prevailing community standards. Payment rates for child care shall be established pursuant to 441—subrule 170.4(7).

f. Prior payment authorization shall be issued by the service area manager before tangible goods, child care, and ancillary services are purchased by or for foster parents.

This rule is intended to implement Iowa Code section 234.35.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 0856C**, IAB 7/24/13, effective 7/1/13; **ARC 1062C**, IAB 10/2/13, effective 11/6/13; **ARC 2885C**, IAB 1/4/17, effective 3/1/17; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—156.9(234) Rate of payment for foster group care.

156.9(1) *In-state reimbursement.* Effective July 1, 2014, contracted foster group care facilities licensed or approved in the state of Iowa shall be paid for group care maintenance and child welfare services in accordance with contracted terms.

a. Additional payment for group care maintenance may be authorized if a facility provides care for a mother and her young child according to subrule 156.9(4).

b. No less than annually, the department shall redetermine the allocation of the combined child welfare service per diem rate between the maintenance and service portions plus the inflation factor based on review of the verified Form 470-5421, Combined Cost Report. If the new allocation differs from the current allocation, the department shall:

(1) Reallocate the combined child welfare service per diem for foster group care between the maintenance and service portions plus the inflation factor of the combined rate; and

(2) Notify all providers of any change in the allocation between maintenance and service rates.

156.9(2) *Out-of-state group care payment rate.* When the department determines that appropriate care is not available in Iowa and a licensed or approved contractor outside Iowa is used, the payment rate for contracted foster group care services shall be the Iowa rate unless the director grants an exception. The rate shall not exceed the rate paid for clients from that state.

156.9(3) *Out-of-state placement determination.*

a. *Placement.* When determining whether appropriate care is available within the state, the director shall consider each of the following:

(1) Whether the child's treatment needs are exceptional.

(2) Whether appropriate in-state alternatives are available.

(3) Whether an appropriate in-state alternative could be developed by using juvenile court-ordered service funds or wrap-around funds.

(4) Whether the placement and additional payment are expected to be time-limited with anticipated outcomes identified.

(5) If the placement has been approved by the service area manager or chief juvenile court officer.

b. *Procedure.* The service area manager or chief juvenile court officer shall submit the request for director's exception to the Appeals Section, Department of Human Services, Hoover State Office Building, Fifth Floor, Des Moines, Iowa 50319-0114. This request shall be made in advance of placing the child and should allow a minimum of two weeks for a response. The request shall contain documentation addressing the criteria for director's approval listed in paragraph 156.9(3)*"a."*

c. *Appeals.* The decision of the director regarding approval of an exception to the rate determination in rule 441—156.9(234) is not appealable.

156.9(4) *Mother-young child rate.* When a group foster care facility provides foster care for a mother and her young child, an additional maintenance rate shall cover the maintenance needs of the young child. No additional amount shall be allowed for service needs of the child.

a. The rate shall be set in the provider contract. The young child maintenance rate shall be limited to the costs associated with food, clothing, shelter, personal incidentals, and supervision for each young child and shall not exceed the maintenance rate for the mother. Costs for day care shall not be included in the maintenance rate.

b. Unless the court has transferred custody from the mother, the mother shall have primary responsibility for providing supervision and parenting for the young child. The facility shall provide

services to the mother to assist her to meet her parenting responsibilities and shall monitor her care of the young child.

c. The provider shall provide services to the mother to assist her to:

(1) Obtain a high school diploma or high school equivalency.

(2) Develop preemployment skills.

(3) Establish paternity for her young child whenever appropriate.

(4) Obtain child support for the young child whenever paternity is established.

d. The provider shall maintain information in the mother's file on:

(1) The involvement of the mother's parents or of other adults.

(2) The involvement of the father of the minor's child, including steps taken to establish paternity, if appropriate.

(3) A decision of the minor to keep and raise her young child.

(4) Plan for the minor's completion of high school or a high school equivalency program.

(5) The parenting skills of the minor parent.

(6) Child care and transportation plans for education, training or employment.

(7) Ongoing health care of the mother and child.

(8) Other services as needed to address personal or family problems or to facilitate the personal growth and development toward economic self-sufficiency of the minor parent and young child.

e. The provider shall designate $35 of the young child rate as an allowance to the mother to meet the maintenance needs of her young child, as defined in her case permanency plan.

This rule is intended to implement Iowa Code sections 234.6 and 234.38.

[**ARC 7741B**, IAB 5/6/09, effective 7/1/09; **ARC 8715B**, IAB 5/5/10, effective 7/1/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 1523C**, IAB 7/9/14, effective 7/1/14; **ARC 1607C**, IAB 9/3/14, effective 10/8/14; **ARC 2885C**, IAB 1/4/17, effective 3/1/17]

441—156.10(234) Payment for reserve bed days.

156.10(1) *Group care facilities.* The department shall provide payment for group care maintenance and child welfare services according to the following requirements.

a. *Family visits.* Reserve bed payment shall be made for days a child is absent from the facility for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The facility shall notify the worker of each visit and its planned length prior to the visit.

(3) The intent of the department and the facility shall be for the child to return to the facility after the visit.

(4) Staff from the facility shall be available to provide support to the child and family during the visit.

(5) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(6) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(7) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(8) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(9) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. *Hospitalization.* Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

c. *Runaways.* Reserve bed payment shall be made for days a child is absent from the facility after the child has run away when the absence is in accord with the following:

(1) The facility shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the facility shall be for the child to return to the facility once the child is found.

(3) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(4) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(7) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

d. *Preplacement visits.* Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

156.10(2) *Foster family care.*

a. *Family visits.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for family visits when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home after the visit.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

b. *Hospitalization.* Reserve bed payment shall be made for days a foster child is absent from the foster family home for hospitalization when the absence is in accord with the following:

(1) The intent of the department and the foster family shall be for the child to return to the foster family home after the hospitalization.

(2) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(3) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(4) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(5) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

c. Runaways. Reserve bed payment shall be made for days a foster child is absent from the foster family home after the child has run away when the absence is in accord with the following:

(1) The foster family shall notify the worker within 24 hours after the child runs away.

(2) The intent of the department and the foster family shall be for the child to return to the foster family home once the child is found.

(3) Payment shall be canceled and payments returned if the foster family refuses to accept the child back.

(4) If the department and the foster family agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(5) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(6) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

d. Preplacement visits. Reserve bed payment shall be made when a foster child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the foster family home shall be for the child to return to the foster family home.

(3) Payment shall be canceled and payment returned if the foster family home refuses to accept the child back.

(4) Payment shall not exceed two consecutive days.

156.10(3) *Shelter care facilities.*

a. Hospitalization. Reserve bed payment shall be made for days a child is absent from the facility for hospitalization when the absence is in accord with the following:

(1) The facility shall contact the worker at least 48 hours in advance of a planned hospitalization and within 24 hours after an unplanned hospitalization.

(2) The intent of the department and the facility shall be for the child to return to the facility after the hospitalization.

(3) Staff from the facility shall be available to provide support to the child and family during the hospitalization.

(4) Payment shall be canceled and payments returned if the facility refuses to accept the child back.

(5) If the department and the facility agree that the return would not be in the child's best interest, payment shall be canceled effective the day after the joint decision not to return the child.

(6) Payment shall be canceled effective the day after a decision is made by the court or parent in a voluntary placement not to return the child.

(7) Payment shall not exceed 14 consecutive days, except upon prior written approval of the service area manager. In no case shall payment exceed 30 consecutive days.

(8) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

b. Preplacement visits. Reserve bed payment shall be made when a child is making a planned preplacement visit to another foster care placement or an adoptive placement when the absence is in accord with the following:

(1) The visits shall be consistent with the child's case permanency plan.

(2) The intent of the department and the facility shall be for the child to return to the facility.

(3) Staff from the facility shall be available to provide support to the child and provider during the visit.

(4) Payment shall be canceled and payment returned if the facility refuses to accept the child back.

(5) Payment shall not exceed two consecutive days.

(6) The provider shall document the use of reserve bed days in the daily log and report the number of reserve bed days claimed in the quarterly report.

This rule is intended to implement Iowa Code sections 234.6 and 234.35.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2885C**, IAB 1/4/17, effective 3/1/17]

441—156.11(234) Emergency juvenile shelter care payment. Contracted juvenile shelter care facilities approved or licensed in Iowa shall be paid according to the following rate-setting methodology.

156.11(1) The combined service and maintenance reimbursement rate paid to a shelter care provider shall be based on the verified Form 470-5421, Combined Cost Report, submitted to the department, but shall not exceed the prevailing rate. The department shall adjust the provider's reimbursement rate to the provider's actual and allowable cost, plus the inflation factor and the $3.99 allowance originated under the tobacco settlement fund, or to the prevailing rate, whichever is less, effective the first day of the month following the department's receipt from the fiscal consultant of the provider's verified cost for the most recently reviewed fiscal year.

156.11(2) Net allowable expenditures are limited to those costs that are considered reasonable, necessary, and related to the service provided to the client as set forth in Comm. 502 (7/16), Instructions for the Combined Cost Report.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 2885C**, IAB 1/4/17, effective 3/1/17]

441—156.12(234) Supervised apartment living.

156.12(1) *Maintenance.* Effective July 1, 2013, when a child at least aged 16½ but under the age of 20 is living in a supervised apartment living situation, the monthly maintenance payment for the child shall be $787.50. This payment may be paid to the child or another payee, other than a department employee, for the child's living expenses.

156.12(2) *Service.* When services for a youth in supervised apartment living are purchased, the service components and number of hours purchased shall be specified by the service worker in the youth's case permanency plan.

This rule is intended to implement Iowa Code section 234.35 and 2011 Iowa Acts, House File 649, section 28(4).

[**ARC 8451B**, IAB 1/13/10, effective 1/1/10; **ARC 8653B**, IAB 4/7/10, effective 5/12/10; **ARC 9778B**, IAB 10/5/11, effective 11/9/11; **ARC 0856C**, IAB 7/24/13, effective 7/1/13; **ARC 1062C**, IAB 10/2/13, effective 11/6/13]

441—156.13(234) Excessive rates. Rescinded IAB 6/9/93, effective 8/1/93.

441—156.14(234,252C) Voluntary placements. When placement is made on a voluntary basis, the parent or guardian shall complete and sign Form 470-0715, Voluntary Placement Agreement.

441—156.15(234) Child's earnings. Earned income of a child who is in foster care shall be reported to the department, and the earned income's use shall be part of the child's plan for service, but the income shall not be used towards the cost of the child's care as established by the department.

[**ARC 2885C**, IAB 1/4/17, effective 3/1/17]

441—156.16(234) Trust funds and investments.

156.16(1) When the child is a beneficiary of a trust and the proceeds therefrom are not currently available, or are not sufficient to meet the child's needs, the worker shall assist the child in having a petition presented to the court requesting release of funds to help meet current requirements. When the child and responsible adult cooperate in necessary action to obtain a ruling of the court, income shall not be considered available until the decision of the court has been rendered and implemented. When the child and responsible adult do not cooperate in the action necessary to obtain a ruling of the court, the

trust fund or investments shall be considered as available to meet the child's needs immediately. When the child or responsible adult does not cooperate within 90 days in making the income available the maintenance payment shall be terminated.

156.16(2) The Iowa department of human services shall be payee for income from any trust funds or investments unless limited by the trust.

156.16(3) Savings accounts from any income and proceeds from the liquidation of securities shall be placed in the child's account maintained by the department and any amount in excess of $1,500 shall be applied towards cost of the child's maintenance.

This rule is intended to implement Iowa Code section 234.39.

441—156.17(234) Preadoptive homes. Payment for a foster child placed in a preadoptive home shall be limited to the amount negotiated pursuant to rule 441—201.5(600) and shall not exceed the foster care maintenance amount paid in family foster care.

This rule is intended to implement Iowa Code section 234.38.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—156.18(237) Foster parent training expenses. Rescinded IAB 7/29/09, effective 10/1/09.

441—156.19(237) Rate of payment for care in a residential care facility. Rescinded **ARC 2885C**, IAB 1/4/17, effective 3/1/17.

441—156.20(234) Eligibility for foster care payment.

156.20(1) *Client eligibility.* Foster care payment shall be limited to the following populations.

a. Youth under the age of 18 shall be eligible based on legal status, subject to certain limitations.

(1) Legal status. The youth's placement shall be based on one of the following legal statuses:

1. The court has ordered foster care placement pursuant to Iowa Code section 232.52(2)*"d,"* 232.102(1), 232.117, or 232.182(5).

2. The child is placed in shelter care pursuant to Iowa Code section 232.20(1) or 232.21.

3. The department has agreed to provide foster care under a voluntary placement agreement pursuant to rule 441—202.3(234).

(2) Limitations. Department payment for group care shall be limited to placements that have been authorized by the department and that conform to the service area group care plan developed pursuant to rule 441—202.17(232). Payment for an out-of-state group care placement shall be limited to placements approved pursuant to 441—subrule 202.8(2).

b. Youth aged 18 and older who meet the definition of child in rule 441—202.1(234) shall be eligible based on age, a voluntary placement agreement pursuant to 441—subrule 202.3(3), and type of placement.

(1) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 18 years of age shall be limited to family foster care or supervised apartment living.

(2) Except as provided in subparagraph 156.20(1)*"b"*(3), payment for a child who is 19 years of age shall be limited to supervised apartment living.

(3) Exceptions. An exception to subparagraphs (1) and (2) shall be granted for all unaccompanied refugee minors. The child's eligibility for the exception shall be documented in the case record. The service area manager or designee shall grant an exception for other children when the child meets all of the following criteria.

1. The child does not have an intellectual disability. Funding for services for persons with an intellectual disability is the responsibility of the county or state pursuant to Iowa Code section 222.60.

2. The child is at imminent risk of becoming homeless or of failing to graduate from high school or obtain a general equivalency diploma. "At imminent risk of becoming homeless" shall mean that a less restrictive living arrangement is not available.

3. The placement is in the child's best interests.

4. Funds are available in the service area's allocation. When the service area manager has approved payment for foster care pursuant to this subparagraph, funds that may be necessary to provide

payment for the time period of the exception, not to exceed the current fiscal year, shall be considered encumbered and no longer available. Each service area's funding allocation shall be based on the service area's portion of the total number of children in foster care on March 31 preceding the beginning of the fiscal year, who would no longer be eligible for foster care during the fiscal year due to age, excluding unaccompanied refugee minors.

c. A young mother shall be eligible for the extra payment for her young child living with her in care as set forth in paragraph 156.6(4)*"a"* and subrule 156.9(4) if all of the following apply:

(1) The mother is placed in foster care.

(2) The mother's custodian determines, as documented in the mother's case permanency plan, that it is in her best interest and the best interest of the young child that the child remain with her.

(3) A placement is available.

(4) The mother agrees to refund to the department any child support payments she receives on behalf of the child and to allow the department to be made payee for any other unearned income for the child.

156.20(2) *Provider eligibility for payment.* Providers of foster care services shall have a foster care services contract under 441—Chapter 152 in force.

This rule is intended to implement Iowa Code sections 232.143, 234.35 and 234.38.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2885C**, IAB 1/4/17, effective 3/1/17]

[Filed 7/1/74; amended 9/4/74]
[Filed emergency 10/31/75—published 11/17/75, effective 11/1/75]
[Filed 12/23/75, Notice 11/17/75—published 1/12/76, effective 2/16/76]
[Filed 2/19/76, Notice 1/12/76—published 3/8/76, effective 4/12/76]
[Filed emergency 7/29/76—published 8/23/76, effective 9/1/76]
[Filed 10/7/76, Notice 8/23/76—published 11/3/76, effective 12/8/76]
[Filed 6/10/77, Notice 5/4/77—published 6/29/77, effective 8/3/77]
[Filed 5/24/78, Notice 3/22/78—published 6/14/78, effective 7/19/78]
[Filed emergency 7/28/78—published 8/23/78, effective 8/1/78]
[Filed emergency 6/26/79—published 7/25/79, effective 7/1/79]
[Filed emergency 6/30/80—published 7/23/80, effective 7/1/80]
[Filed 10/24/80, Notice 9/3/80—published 11/12/80, effective 12/17/80]
[Filed emergency 6/30/81—published 7/22/81, effective 7/1/81]
[Filed 6/30/81, Notice 4/29/81—published 7/22/81, effective 9/1/81]
[Filed emergency 8/20/82—published 9/15/82, effective 9/1/82]
[Filed 2/25/83, Notice 12/22/82—published 3/16/83, effective 5/1/83]
[Filed emergency after Notice 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 6/17/83—published 7/6/83, effective 7/1/83]
[Filed emergency 10/7/83—published 10/26/83, effective 11/1/83]
[Filed without Notice 10/7/83—published 10/26/83, effective 12/1/83]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed emergency 6/15/84—published 7/4/84, effective 7/1/84]
[Filed 6/15/84, Notice 5/9/84—published 7/4/84, effective 9/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed emergency 11/16/84—published 12/5/84, effective 12/1/84]
[Filed 1/21/85, Notice 12/5/84—published 2/13/85, effective 4/1/85]
[Filed 4/29/85, Notice 2/27/85—published 5/22/85, effective 7/1/85]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed emergency 10/1/85—published 10/23/85, effective 11/1/85]
[Filed without Notice 10/1/85—published 10/23/85, effective 12/1/85]
[Filed 12/2/85, Notice 10/23/85—published 12/18/85, effective 2/1/86]
[Filed 12/12/85, Notice 10/9/85—published 1/1/86, effective 3/1/86]
[Filed emergency 6/26/86—published 7/16/86, effective 7/1/86]

[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87][◊]
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87][◊]
[Filed emergency 9/21/87—published 10/21/87, effective 9/22/87]
[Filed 10/23/87, Notice 7/15/87—published 11/18/87, effective 1/1/88]
[Filed 12/10/87, Notice 10/21/87—published 12/30/87, effective 3/1/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 4/13/89, Notice 1/11/89—published 5/3/89, effective 7/1/89]
[Filed emergency 6/9/89—published 6/28/89, effective 7/1/89]
[Filed 7/13/89, Notice 5/31/89—published 8/9/89, effective 10/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 11/1/89]
[Filed emergency 6/20/90—published 7/11/90, effective 7/1/90]
[Filed 8/16/90, Notice 7/11/90—published 9/5/90, effective 11/1/90]
[Filed 10/12/90, Notice 7/11/90—published 10/31/90, effective 1/1/91]
[Filed 11/15/91, Notice 9/18/91—published 12/11/91, effective 2/1/92]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92][1]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notice 7/8/92—published 9/2/92, effective 11/1/92]
[Filed 5/14/93, Notice 3/17/93—published 6/9/93, effective 8/1/93]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]
[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notice 2/17/93—published 9/1/93, effective 11/1/93]
[Filed 9/17/93, Notice 7/21/93—published 10/13/93, effective 1/1/94]
[Filed emergency 10/14/93—published 11/10/93, effective 11/1/93]
[Filed 11/12/93, Notice 9/15/93—published 12/8/93, effective 2/1/94]
[Filed 12/16/93, Notices 10/13/93, 11/10/93—published 1/5/94, effective 3/1/94]
[Filed emergency 5/11/94 after Notice 3/16/94—published 6/8/94, effective 6/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
[Filed emergency 12/15/94—published 1/4/95, effective 2/1/95]
[Filed 12/15/94, Notice 10/26/94—published 1/4/95, effective 3/1/95]
[Filed 2/16/95, Notice 1/4/95—published 3/15/95, effective 5/1/95]
[Filed 3/20/95, Notice 1/18/95—published 4/12/95, effective 6/1/95]
[Filed 4/13/95, Notices 2/15/95, 3/1/95—published 5/10/95, effective 7/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed emergency 7/12/95—published 8/2/95, effective 9/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed 9/25/95, Notice 8/2/95—published 10/11/95, effective 12/1/95]
[Filed 2/14/96, Notice 12/20/95—published 3/13/96, effective 5/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 8/1/96]
[Filed 8/15/96, Notices 6/19/96, 7/3/96—published 9/11/96, effective 11/1/96]
[Filed 9/17/96, Notice 7/17/96—published 10/9/96, effective 12/1/96]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 8/13/97, Notice 7/2/97—published 9/10/97, effective 11/1/97]
[Filed 10/15/97, Notice 7/30/97—published 11/5/97, effective 1/1/98]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed emergency 10/14/98 after Notice 8/26/98—published 11/4/98, effective 11/1/98]

[Filed emergency 6/10/99—published 6/30/99, effective 7/1/99]
[Filed 7/15/99, Notice 6/2/99—published 8/11/99, effective 10/1/99]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed emergency 10/13/99 after Notice 8/25/99—published 11/3/99, effective 11/1/99]
[Filed emergency 6/8/00—published 6/28/00, effective 7/1/00]
[Filed 8/9/00, Notice 6/14/00—published 9/6/00, effective 11/1/00]
[Filed 1/10/01, Notice 11/15/00—published 2/7/01, effective 4/1/01]
[Filed emergency 6/13/01—published 7/11/01, effective 7/1/01]
[Filed 9/11/01, Notice 7/11/01—published 10/3/01, effective 12/1/01]
[Filed 11/18/02, Notice 8/21/02—published 12/11/02, effective 2/1/03]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed emergency 6/17/05—published 7/6/05, effective 7/1/05]
[Filed 10/21/05, Notice 7/6/05—published 11/9/05, effective 12/14/05]
[Filed emergency 6/16/06—published 7/5/06, effective 7/1/06][◊]
[Filed 9/19/06, Notices 7/5/06—published 10/11/06, effective 11/16/06]
[Filed emergency 10/12/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06 after Notice 11/8/06—published 1/3/07, effective 1/1/07]
[Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]
[Filed emergency 6/13/07—published 7/4/07, effective 7/1/07]
[Filed 9/12/07, Notice 7/4/07—published 10/10/07, effective 11/14/07]
[Filed emergency 6/12/08—published 7/2/08, effective 7/1/08]
[Filed 8/19/08, Notice 7/2/08—published 9/10/08, effective 10/15/08]
[Filed ARC 7606B (Notice ARC 7372B, IAB 12/3/08), IAB 3/11/09, effective 5/1/09]
[Filed ARC 7741B (Notice ARC 7526B, IAB 1/28/09), IAB 5/6/09, effective 7/1/09]
[Filed ARC 8010B (Notice ARC 7712B, IAB 4/8/09), IAB 7/29/09, effective 10/1/09]
[Filed Emergency ARC 8451B, IAB 1/13/10, effective 1/1/10]
[Filed ARC 8653B (Notice ARC 8452B, IAB 1/13/10), IAB 4/7/10, effective 5/12/10]
[Filed ARC 8715B (Notice ARC 8490B, IAB 1/27/10), IAB 5/5/10, effective 7/1/10]
[Filed Emergency ARC 8904B, IAB 6/30/10, effective 7/1/10]
[Filed ARC 9778B (Notice ARC 9625B, IAB 7/27/11), IAB 10/5/11, effective 11/9/11]
[Filed Emergency ARC 0240C, IAB 8/8/12, effective 7/11/12]
[Filed ARC 0419C (Notice ARC 0241C, IAB 8/8/12), IAB 10/31/12, effective 12/5/12]
[Filed Emergency ARC 0858C, IAB 7/24/13, effective 7/1/13]
[Filed Emergency ARC 0856C, IAB 7/24/13, effective 7/1/13]
[Filed ARC 1061C (Notice ARC 0857C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed ARC 1062C (Notice ARC 0855C, IAB 7/24/13), IAB 10/2/13, effective 11/6/13]
[Filed Emergency ARC 1523C, IAB 7/9/14, effective 7/1/14]
[Filed ARC 1607C (Notice ARC 1522C, IAB 7/9/14), IAB 9/3/14, effective 10/8/14]
[Filed ARC 2885C (Notice ARC 2771C, IAB 10/12/16), IAB 1/4/17, effective 3/1/17]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

◊ Two or more ARCs

1 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.

CHAPTER 202
FOSTER CARE PLACEMENT AND SERVICES

[Prior to 7/1/83, Social Services[770] Ch 136]
[Previously appeared as Ch 136—renumbered IAB 2/29/84]
[Prior to 2/11/87, Human Services[498]]

441—202.1(234) Definitions.

"Age- or developmentally appropriate activities" means activities or items that are generally accepted as suitable for children of the same chronological age or level of maturity or that are determined to be developmentally appropriate for a child, based on the development of cognitive, emotional, physical, and behavioral capacities that are typical for an age or age group; and in the case of a specific child, activities or items that are suitable for the child based on the developmental stages attained by the child with respect to the cognitive, emotional, physical, and behavioral capacities of the child.

"Case permanency plan" shall mean the plan identifying goals, needs, strengths, problems, services, time frames for meeting goals and for delivery of the services to the child and parents, objectives, desired outcomes, and responsibilities of all parties involved and reviewing progress.

"Child" shall mean the same as defined by Iowa Code section 234.1.

"Department" shall mean the Iowa department of human services and includes the local offices of the department.

"Eligible child" shall mean a child for whom the court has given guardianship to the department or has transferred legal custody to the department or for whom the department has agreed to provide foster care services on the basis of a signed placement agreement or who has been placed in emergency care for a period of not more than 30 days upon the approval of the director or the director's designee.

"Facility" means the personnel, program, plant and equipment of a person or agency providing child foster care.

"Family safety, risk, and permanency service" means a service provided under 441—Chapter 172 that uses strategies and interventions designed to achieve safety and permanency for a child with an open department child welfare case, regardless of the setting in which the child resides.

"Foster care" shall mean substitute care furnished on a 24-hour-a-day basis to an eligible child in a licensed or approved facility by a person or agency other than the child's parent or guardian but does not include care provided in a family home through an informal arrangement for a period of 20 days or less. Child foster care shall include but is not limited to the provision of food, lodging, training, education, supervision, and health care.

"Natural parent" shall mean a parent by blood, marriage, or adoption.

"Person" or *"agency"* shall mean individuals, institutions, partnerships, voluntary associations, and corporations, other than institutions under the management or control of the department, who are licensed by the department as a foster family home, child caring agency or child placing agency, or approved as a shelter care facility.

"Reasonable and prudent parent standard" means the standard characterized by careful and sensible parental decisions that maintain the health, safety, and best interests of a child while at the same time encourage the emotional and developmental growth of the child, that a caregiver shall use when determining whether to allow a child in foster care under the responsibility of the state to participate in extracurricular, enrichment, cultural, and social activities. For the purposes of this definition, "caregiver" means a foster parent with whom a child in foster care has been placed or a designated official for a child care institution (including group homes, residential treatment, shelters, or other congregate care settings) in which a child in foster care has been placed.

"Resource family" means an individual person or married couple who is licensed to provide foster family care or approved for adoption.

"Safety-related information" means information that indicates whether the child has behaved in a manner that threatened the safety of another person, has committed a violent act causing bodily injury to another person, or has been a victim or perpetrator of sexual abuse.

"Service area manager" shall mean the department employee responsible for managing department offices and personnel within the service area and for implementing policies and procedures of the department.

"Social history" or *"child study"* means a written description of the child that includes strengths and needs; medical, mental, social, educational, placement and court history; and the child's relationships with the birth family and significant others.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 2069C**, IAB 8/5/15, effective 10/1/15]

441—202.2(234) Eligibility.

202.2(1) Only an eligible child as defined in these rules shall be considered for foster care services supervised by the department.

202.2(2) The need for foster care placement and social and other related services, including but not limited to medical, psychiatric, psychological, and educational services, shall be determined by an assessment of the child and family to determine their needs and the appropriateness of services.

a. Assessments shall include:

(1) The educational, physical, psychological, social, family living, and recreational needs of the child,

(2) The family's ability to meet those needs, and

(3) A family genogram to determine relatives and other suitable support persons who have a kinship bond with the child.

b. The assessment is a continual process to identify needed changes in service or placement for the child.

202.2(3) With the exception of emergency care, a social history shall be completed on each child before a department recommendation for foster care placement, using the outline RC-0027, Social History Format.

a. For voluntary emergency placements, a social history shall be completed before a decision is made to extend the placement beyond 30 days.

b. For court-ordered emergency placements, a social history shall be completed before the disposition hearing.

202.2(4) Foster care placement shall be recommended by the department only after efforts have been made to prevent or eliminate the need for removal of the child from the family unless the child is in immediate danger at home.

202.2(5) The need for foster care and the efforts to prevent placement shall be evaluated by a review committee prior to placement or, for emergency placements only, within 30 days after the date of placement. For children who are mentally retarded or developmentally disabled and receive case management services, this requirement may be met by the interdisciplinary staffing described in 441—Chapter 90, as long as the service area manager approves, the department worker attends the staffing, and the staffing meets the requirements of paragraphs *"b"* to *"h"* below.

The review shall meet the following requirements:

a. Department staff on the review committee shall be the child's service worker, a supervisor knowledgeable in child welfare, and one or more additional persons appointed by the service area manager.

b. The review shall be open to the participation of the parents or guardian of the child, local and area education staff, juvenile court staff, the guardian ad litem, current service providers and previous service providers who have maintained a license.

c. The present foster care provider, if any, shall be notified of the review and have the opportunity to participate.

d. Written notice of the review shall be sent to the child's parents or guardian at least five working days prior to the date of the review.

e. Other persons may be invited to the review with the consent of the parents or guardian.

f. A written summary of the review recommendations shall be sent to the child's parents or guardian following the review.

g. Review committee recommendations shall be advisory to the service worker and supervisor, who are responsible for development of the department case plan and for reports and recommendations to the juvenile court.

h. At least one of the persons on the review committee shall be someone without responsibility for the case management or the delivery of services to either the child or the parents or guardian who are the subject of the review.

202.2(6) The citizenship or alien status of a child who enters foster care must be verified.

a. When the child will remain in foster care for no more than 60 days, Form 470-4500, Statement of Citizenship Status: Foster Care, signed by the parent or guardian of the child is sufficient.

b. When the child will remain in foster care for more than 60 days, one of the documents listed in this paragraph is required. Any one of the following documents shall be accepted as satisfactory documentation of citizenship or nationality:

(1) A certificate of birth in the United States.

(2) Form FS-240 (Report of Birth Abroad of a Citizen of the United States) issued by the U.S. Citizenship and Immigration Services.

(3) Form FS-545 or Form DS-1350 (Certification of Birth Abroad) issued by the U.S. Citizenship and Immigration Services.

(4) A United States passport.

(5) Form I-97 (United States Citizen Identification Card) issued by the U.S. Citizenship and Immigration Services.

(6) Form N-560 or N-561 (Certificate of United States Citizenship) issued by the U.S. Citizenship and Immigration Services.

(7) Form N-550 or N-570 (Certificate of Naturalization) issued by the U.S. Citizenship and Immigration Services.

(8) 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.

(9) 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 by regulation pursuant to 42 U.S.C. Section 1396b(x)(3)(B)(v) or 1396b(x)(3)(C)(v).

c. A child entering foster care is exempt from these requirements when the family has previously presented satisfactory documentary evidence of citizenship, as specified by the Secretary of the U.S. Department of Health and Human Services.

d. The parent or guardian of the child shall have a reasonable period to obtain and provide proof of citizenship. For the purposes of this requirement, the "reasonable period" begins on the date when the child is placed in foster care and continues to the date when the proof is provided or when the department establishes that the parent or guardian is no longer making a good-faith effort to obtain the proof.

This rule is intended to implement Iowa Code sections 234.6(1) and 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.3(234) Voluntary placements.

202.3(1) All voluntary placement agreements initiated after July 1, 2003, for children under the age of 18 shall terminate after 90 days.

202.3(2) When the voluntary placement is of a child who is under the age of 18, a Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the parent(s) or guardian and the county office where the parent or guardian resides. Voluntary Foster Care Placement Agreements shall not be used to place children outside Iowa and shall not be signed with parents or guardians who

reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's parent or guardian moves outside Iowa after the placement.

202.3(3) Voluntary placement of a child aged 18 or older may be granted for six months at a time.

a. The department shall enter into the agreement only when the child:

(1) Meets the definition of "child" in Iowa Code section 234.1,

(2) Was in foster care or a state institution immediately before reaching the age of 18,

(3) Has continued in foster care or a state institution since reaching the age of 18,

(4) Has demonstrated a willingness to participate in case planning and to fulfill responsibilities as defined in the case permanency plan, and

(5) Will be placed in foster family care or supervised apartment living in Iowa.

b. Payment shall be limited pursuant to 441—paragraph 156.20(1)*"b."*

c. When the voluntary placement is of a child who is aged 18 or older and who has a court-ordered guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the guardian and the local office where the guardian resides. Voluntary Foster Care Placement Agreements shall not be signed with guardians who reside outside Iowa. Voluntary Foster Care Placement Agreements shall terminate if the child's guardian moves outside Iowa after the placement.

d. When the voluntary placement is of a child who is aged 18 or older and who does not have a court-appointed guardian, the Voluntary Foster Care Placement Agreement, Form 470-0715, shall be completed and signed by the child and the local office where the child resides.

e. An exception to the requirement for continuous placement may be made for a youth who leaves foster care at age 18 and voluntarily returns to supervised apartment living foster care before the youth's twentieth birthday in order to complete high school or obtain a general equivalency diploma (GED).

202.3(4) All voluntary placements shall be approved by the service area manager or designee.

This rule is intended to implement Iowa Code sections 234.6(6)*"b"* and 234.35(1)*"c."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.4(234) Selection of facility.

202.4(1) Placement consistent with the best interests and special needs of the child shall be made in the least restrictive, most family-like facility available and in close proximity to the child's home. Race, color, or national origin may not be routinely considered in placement selections.

202.4(2) Efforts shall be made to place siblings together unless to do so would be detrimental to any of the children's physical, emotional or mental well-being. Efforts to prevent separating siblings, reasons for separating siblings, and plans to maintain sibling contact shall be documented in the child's case permanency plan.

202.4(3) The department shall first consider placing the child in a relative's home unless no relatives are available or willing to accept placement or such placement would be detrimental to the child's physical, emotional or mental well-being.

a. If a relative or a suitable person who has a kinship bond with the child will accept placement of the child:

(1) The person shall sign Form 595-1489, Non-Law Enforcement Record Check Request, and

(2) The department shall complete record checks as listed in 441—subrule 113.13(1) to evaluate if the person's home is appropriate for the child before making the placement.

b. Efforts to place the child in a relative's home and reasons for using a nonrelative placement shall be documented in the child's case permanency plan.

202.4(4) If the child cannot be placed with a relative or a suitable person who has a kinship bond with the child, foster family care shall be used for a child unless the child has problems which require specialized services that cannot be provided in a family setting. Reasons for using a more restrictive placement shall be documented in the child's case permanency plan.

202.4(5) A foster family shall be selected on the basis of compatibility with the child, taking into consideration:

a. The extent to which interests, strengths, abilities and needs of the foster family enable the foster family members to understand, accept and provide for the individual needs of the child.

b. The child's individual problems, medical needs, and plans for future care. The department shall not place a child with asthma or other respiratory health issues in a foster home where any member of the household smokes.

c. The capacity of the foster family to understand and accept the child's case permanency plan, the needs and attitudes of the child's parents, and the relationship of the child to the parents.

d. The characteristics of the foster family that offer a positive experience for the child who has specific problems as a consequence of past relationships.

e. An environment that will cause minimum disruption of the child including few changes in placement for the child.

f. Rescinded IAB 4/11/07, effective 7/1/07.

202.4(6) A foster group care facility shall be selected on the basis of its ability to meet the needs of the child, promote the child's growth and development, and ensure physical, intellectual and emotional progress during the stay in the facility. The department shall place a child only in a licensed or approved facility which has a current contract with the department pursuant to 441—Chapter 152.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.5(234) Preplacement.

202.5(1) Except for placements made in less than 24 hours, a child placed in a facility shall have a preplacement visit involving:

a. The child,

b. The foster parents or agency staff, if the child is placed in a public or private agency,

c. The department service worker, and

d. The child's parents, unless their presence would be disruptive to the child's placement.

202.5(2) Before placement, the worker shall provide the facility with general information regarding the child, including a description of the child's medical needs, behavioral patterns including safety-related information, educational plans, and permanency goal. Safety-related information shall be withheld only if:

a. Withholding the information is ordered by the court; or

b. The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

202.5(3) The child shall have a physical examination by a physician, advanced registered nurse practitioner, or a physician assistant before the initial placement into foster care, or the physical examination shall be scheduled within 14 calendar days of placement. The physician, advanced registered nurse practitioner, or a physician assistant shall complete a preliminary screening for dental and mental health and refer the child to a dentist or mental health professional if appropriate. To address any immediate medical needs, the child shall be seen immediately at an emergency room, an urgent care center, or other community health resource.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 3185C**, IAB 7/5/17, effective 9/1/17]

441—202.6(234) Placement.

202.6(1) At the time of placement, the department worker shall furnish to the foster care provider any available information regarding the child.

a. The information provided shall include:

(1) The child's full name and date of birth;

(2) The names, work addresses, and telephone numbers of the placement worker and the worker's supervisor, including a home telephone, cell phone, or on-call number;

(3) The names, addresses, and telephone numbers of the child's physician and dentist;

(4) The names, addresses, and telephone numbers of significant relatives of the child, including parents, grandparents, brothers and sisters, aunts and uncles, and any other significant persons (for an adopted child, the adoptive parents and adoptive relatives);

(5) The case permanency plan;

(6) The results of a physical examination, including immunization history;

(7) The child's medical needs including allergies, physical limitations, dental and medical recommendations, and special needs of HIV;

(8) Behavioral patterns including safety-related information;

(9) Educational arrangements including, but not limited to, the school the child attends, special education needs, and school contacts;

(10) The placement contract or agreement including the date of acceptance for care;

(11) Medical authorizations, service authorizations, and other releases as needed; and

(12) If the child is an Indian, the identification of the child's tribe and tribal social service agency including telephone number and contact person.

b. Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information.

(1) The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

(2) Form 470-3226, HIV General Agreement, shall be completed by foster parents who have agreed to care for children who have AIDS, test HIV positive, or are at risk for HIV infection.

c. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

202.6(2) For each foster care placement in a foster family home supervised directly by department staff, Form 470-0716 or 470-0716(S), Foster Family Placement Contract, shall be completed by the foster family and the placement worker and supervisor. A new foster family placement contract shall be completed when the rate of payment or special provisions change.

202.6(3) A follow-up visit shall be made to the child at the foster family home within two weeks of the initial placement for placements supervised directly by the department.

202.6(4) The case permanency plan shall be reviewed at least every six months to ensure appropriateness of the child's placement. A copy of the subsequent case plan shall be submitted to the court every six months unless the court orders a different frequency for reports.

202.6(5) In conjunction with the case plan review, the case shall be presented every six months to a review committee which conforms to the requirements in subrule 202.2(5). The service area manager may also approve a review by a local foster care review board authorized in Iowa Code section 237.19 or the court as meeting this requirement as long as the review conforms to subrule 202.2(5), paragraphs *"b"* to *"h,"* and to subrule 202.6(5), paragraphs *"a"* to *"e."* The review committee shall:

a. Evaluate the continuing necessity for foster care placement.

b. Evaluate the continuing appropriateness of the foster care placement.

c. Evaluate the extent of compliance with the case plan.

d. Evaluate the extent of progress made toward lessening the causes for foster care placement.

e. Project a likely date by which the child will leave foster care.

This rule is intended to implement Iowa Code sections 234.6(6)*"b,"* and 237.19.

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.7(234) Out-of-area placements.

202.7(1) When the department makes a placement of a child in the foster care system out of the service area in which the child resides, this placement shall occur only when there is no appropriate placement within the service area, when the placement is necessary to facilitate reunification of the child with the parents, or when an out-of-area agency is closer to the community where the child resides than an in-area agency offering the same services.

202.7(2) The authority for approving out-of-area placements rests with both the placing and receiving service area managers.

202.7(3) Transfer of responsibility for supervision, planning, and visitation shall be approved by the placing and receiving service area managers and, when appropriate, by the court.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.8(234) Out-of-state placements.

202.8(1) The department shall make an out-of-state foster family care placement only with the approval of the service area manager or designee. Approval shall be granted only when the placement will not interfere with the goals of the child's case permanency plan and when one of the following conditions exists:

a. The foster family with whom the child is placed is moving out of state.

b. An out-of-state family having previous knowledge of the child desires to provide foster care to the child.

c. An out-of-state family is approved to adopt the child under subsidy and is eligible to receive maintenance payments until the adoption is final.

d. An out-of-state placement is necessary to facilitate reunification of the child with the parents.

202.8(2) Placements shall be made in an out-of-state group care facility only with the approval of the service area manager or designee.

202.8(3) All out-of-state placements shall be made pursuant to interstate compact procedures.

202.8(4) The reasons for selecting an out-of-state placement shall be documented in the child's case permanency plan.

202.8(5) Regional out-of-state placement committees. Rescinded IAB 7/6/94, effective 7/1/94.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.9(234) Supervised apartment living. A supervised apartment living arrangement shall provide a child with an environment in which the child can experience living in the community with supervision and prepare for self-sufficiency. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting and must be able to follow the provisions of the case plan and participate in activities and services to achieve self-sufficiency.

202.9(1) *Living arrangements.*

a. The two types of supervised apartment living arrangements are as follows:

(1) A cluster setting, which provides support in a structured setting. Up to six children reside in apartments or bedrooms in one building (such as an apartment building or residential housing), supervised by one agency. The supervising agency must have an adult staff member present and available on site in the living arrangement at any time when more than one child is present.

(2) A scattered-site setting, which is the less restrictive of the two types of living arrangements. Up to three children supervised by one agency may reside in individual housing arrangements, such as apartments or residential housing, located in one building. Children must be able to contact supervising agency staff 24 hours a day, seven days a week.

b. If an agency rents an apartment to the child, there shall be a signed lease between both parties that includes, but is not limited to:

(1) Amount to be paid for the rental unit.

(2) The term of the lease with both a beginning and an ending date.

(3) Rights and responsibilities of the tenant.

(4) Rights and responsibilities of the landlord.

(5) Conditions under which the lease can be terminated.

202.9(2) *Eligibility.* To be eligible for supervised apartment living placement, a child shall meet all of the following conditions:

a. The child must be at least 16½ years old for placement in a cluster setting.

b. The child must be at least 17 years old for placement in a scattered-site setting.

c. If the child is under the age of 18, the child must:

(1) Satisfactorily attend school, in accordance with the school's attendance policies, with the objective of obtaining a high school diploma; or

(2) Satisfactorily attend an instructional program, pursuant to the program's policies, necessary to obtain a general equivalency diploma (GED); or

(3) Attend school to obtain postsecondary education or training on a full-time basis (based upon the institution's definition of full-time) or attend on a part-time basis and be either working or participating in a work training program leading to employment; or

(4) Work at least an average of 80 hours per month if not enrolled in school; or

(5) Participate in a work training program leading to employment if not enrolled in school.

d. If the child is aged 18 or older, the child must:

(1) Meet the definition of "child" in Iowa Code section 234.1; and

(2) Have been in foster care immediately before reaching the age of 18 and have continued in foster care since reaching the age of 18. The service area manager or designee may waive the requirement for continuous placement for a child who leaves foster care at age 18 and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a GED, consistent with Iowa Code sections 234.35(1)*"f"* and 234.35(3)*"c"*; and

(3) Attend school on a full-time basis leading to a high school diploma or attend an instructional program leading to a GED.

e. The child must need foster care placement and services, based on an assessment completed according to rule 441—202.2(234) and subrule 202.6(5).

f. The child must participate in services and activities to achieve self-sufficiency.

g. The child must have the capacity to live in the community with less supervision than that provided by a foster family or in a group care setting, as determined by an assessment that reviews available information on the child to identify the needs, strengths, and resources of the child, especially as they pertain to the child's ability to function in the community. To determine if a supervised apartment living foster care placement is suitable for the child, the department worker must complete Form 470-4063, Preplacement Screening for Supervised Apartment Living Foster Care.

h. The child must have an approved living situation that meets the following minimum standards:

(1) Comply with applicable state and local zoning, fire, sanitary and safety regulations.

(2) Be located so as to provide reasonably convenient access to schools, places of employment, and services and supports required by the child.

(3) Be reasonably priced so as to fit within the child's budget.

i. If supervised apartment living foster care is deemed suitable for the child, the worker shall complete Form 470-3186, Request for Approval of Supervised Apartment Living Foster Care Placement, to request that the service area manager or designee approve the placement. This form is also to be used to request that the service area manager or designee waive the requirement for continuous placement for a child who leaves foster care on or after the child's eighteenth birthday and voluntarily returns before the child's twentieth birthday in order to complete high school or obtain a GED.

j. The placement must have the approval of the juvenile court if the child is under court jurisdiction.

202.9(3) *Services to be provided.* To ensure that the supervised apartment living arrangement is meeting the child's needs, required services shall be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. The following services are required:

a. Development of a case or service plan (by either the department worker or the service provider, if contracted out) in consultation with the child and the child's family (unless a reason for noninvolvement is documented in the case record) and significant others whenever appropriate that documents the following:

(1) Goals, intended to meet the specific needs of the child to achieve self-sufficiency, with projected dates of accomplishment.

(2) Objectives (action steps) to be taken by the child, the child's support system, and staff, with projected dates of accomplishment.

(3) Services to be provided and activities to be undertaken, the frequency of such services, who will provide the services, the child's progress with the goals and objectives, and the child's compliance with the service plan.

(4) A budget, developed with the child, based upon the child's monthly maintenance payment, any start-up allowance, any earned or unearned incomes and financially related assistance (e.g., food assistance). Staff will work with the child to ensure payment of bills and receipt of necessary items as outlined in the budget.

b. Life skills training involving interpersonal and daily living skills training to prepare the child to maintain a safe, healthy, and stable lifestyle and achieve self-sufficiency. Life skills training includes training of "hard" skills (e.g., money management, self-care and hygiene, physical and mental health care, skills related to educational and employment goals, housing and home management, time management, accessing community resources) and training of "soft" skills (e.g., decision making, problem solving, developing healthy relationships, self-advocacy). Life skills training should be individualized to the needs of the child toward achieving self-sufficiency. If a child needs a specific life skills training service or services (e.g., parenting skill development, counseling services to reduce stress and social, emotional, or behavioral problems that affect the child's stability or ability to achieve self-sufficiency) in addition to basic life skills training services and services are purchased, the department worker will specify the necessary services under special provisions on Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL).

c. Through visits with the child and to the living situation, determination and documentation that:

(1) The living arrangement and mode of living are safe and suitable and provide an environment that allows for the child's social and emotional needs to be met; and

(2) There is no reasonable cause to believe that the child's living situation or mode of living presents any unacceptable risks to the child's health or safety; and

(3) The child has access to a telephone; and

(4) There is an operating smoke alarm on each level of occupancy; and

(5) The child is receiving any necessary medical care; and

(6) The child is receiving appropriate and sufficient services and supports to achieve the child's goals and facilitate objectives according to the child's service plan.

d. Supervision to assist the child in developing the needed structure to live in the supervised apartment living setting and in locating and using other needed services. If the child is under the age of 18, supervision shall include a minimum of weekly face-to-face contacts. For a child aged 18 or older, supervision shall include a minimum of biweekly (every other week) face-to-face contacts. Supervision may include guidance, oversight, and behavior monitoring.

e. Ongoing assessment activities to monitor the child's ability to achieve self-sufficiency.

f. If services are purchased, visits by the department to the child according to subrule 202.11(2).

g. If services are purchased, compliance by the provider with all reporting requirements as required by the provider's contract with the department, including requirements for the individual service plan, quarterly reports, and a termination summary.

h. A review of the case and case plan every six months, in accordance with subrules 202.6(4) and 202.6(5).

202.9(4) *Method of service provision.* Supervised apartment living services may be provided directly by the department or purchased from an agency that has a contract with the department to provide supervised apartment living foster care services. If services are purchased:

a. Department staff shall be responsible to determine the specific service components and the specific number of service units to be provided for required services. The department case permanency plan shall specify the goals and objectives (action steps) of the services that are being purchased. If services are purchased, the worker shall complete Form 470-5081, Placement Agreement and Service Authorization for Supervised Apartment Living (SAL), to place the child with the contractor and to authorize service codes (scattered-site or cluster setting; individual services or services provided with a group of children in supervised apartment living placement) and the specific number of units to be provided and billable.

b. Service billings for services shall be based on one hour (one unit equals one hour of service), or any portion thereof (with monthly cumulative units rounded up or down to the nearest whole unit), of:

(1) Direct face-to-face contact between the service provider and the child.

(2) Activities undertaken to assist the child in developing the needed structure and supports to live in the supervised apartment living setting.

(3) Activities undertaken to assist the child in locating and using other needed services, supports, and community resources and to consult and collaborate on service directions on behalf of the child with schools, employers, landlords, volunteers, extended family members, peer support groups, training resources, or other community resources.

c. Service billings for group services shall be based on one hour (one unit equals one hour of service), or any portion thereof (with monthly cumulative units rounded up or down to the nearest whole unit), for each child in the group.

d. Expenses of transporting the child, service management activities, and other administrative functions shall be allowable indirect costs subject to the restrictions set forth in 441—subrule 152.2(6) and are not billable units of service.

e. Contractors providing a cluster setting shall be paid $551.25 per month per child in the setting for agency staffing costs, in addition to billable units of services provided to the child, but are eligible for this payment only when two or more children are in the setting. For a child who enters a cluster setting during the month, the prorated amount per day is $18.12. If a child exits the setting on or before the last day of the month, the $551.25 shall be prorated up to the date before the date of exit.

202.9(5) *Termination of services.*

a. Mandatory termination. Supervised apartment living services shall be terminated when the child:

(1) No longer meets eligibility criteria;

(2) No longer needs services or needs a more restrictive level of placement;

(3) Chooses to live in a nonapproved setting; or

(4) Refuses to follow the provisions of the case plan.

b. When services are purchased and the department plans to remove a child from the supervised apartment living placement, the department shall inform the provider in writing of the date of removal, the reason for the removal, the recourse available, if any, and that the contested case (appeal) proceeding does not apply to the removal.

c. The provider shall be informed ten days in advance of the removal, except when the court orders removal of the child from the placement or there is evidence of neglect or physical or sexual abuse.

This rule is intended to implement Iowa Code section 234.6.

[**ARC 0417C**, IAB 10/31/12, effective 1/1/13; **ARC 2342C**, IAB 1/6/16, effective 2/10/16; **ARC 2885C**, IAB 1/4/17, effective 3/1/17]

441—202.10(234) Services to foster parents. Foster parents shall be provided necessary supportive services for the purpose of aiding them in the care and supervision of the child. These services shall include, but not be limited to:

202.10(1) Availability of social service staff on a 24-hour basis in case of emergency.

202.10(2) Conferences to develop in-depth planning regarding family visits, expectations of the department, future objectives and time frames, use of resources, and termination of placements.

202.10(3) Visitation by the service worker at least monthly regardless of the duration of the placements.

202.10(4) Making available all known pertinent information needed for the care of the child including HIV status, safety-related information, and special confidentiality requirements.

a. Before releasing specific information about HIV, the department shall use Form 470-3225, Authorization to Release HIV-Related Information, to obtain a release from the child or the child's parent or guardian, or a court order permitting the release of the information. The person receiving this information shall complete Form 470-3227, Receipt of HIV-Related Information, to document understanding of the confidentiality of this knowledge.

b. Safety-related information shall be withheld only if:

(1) Withholding the information is ordered by the court; or

(2) The department or the agency developing the service plan determines that providing the information would be detrimental to the child or to the family with whom the child is living.

c. When continued breastfeeding of the child is determined to be in the best interest of the child, the service worker and the foster parents shall make reasonable efforts to support the continued breastfeeding of the child by the mother.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.11(234) Services to the child. The department service worker shall maintain a continuous relationship with the child.

202.11(1) The department service worker shall:

a. Help the child plan for the future,

b. Evaluate the child's needs and progress,

c. Supervise the living arrangement,

d. Arrange for social and other related services including, but not limited to, medical, psychiatric, psychological, and educational services from other resources as needed, and

e. Counsel the child in adjusting to the placement.

202.11(2) The assigned department service worker shall personally visit each child in out-of-home care at least once every calendar month, with the frequency of the vists based upon the needs of the child.

a. The visit shall take place in the child's place of residence the majority of the time.

b. The visit shall be of sufficient length to focus on issues pertinent to case planning. During the visit, the worker shall address the safety, permanency, and well-being of the child, including the child's needs, services to the child, and achievement of the case permanency plan goals.

202.11(3) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding for the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

202.11(4) When a child is in continuous foster care, a new physical examination shall not be required when the child transfers from one foster care placement to another unless there is some indication that an examination is necessary. The service worker shall obtain from the health practitioner or practitioners an annual medical review of treatment the child has received.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

202.11(5) Throughout the provision of care, the foster care provider shall actively ensure that the child stays connected to the child's kin, culture, and community as documented in the child's case permanency plan.

202.11(6) Throughout the provision of care, the foster care provider is permitted to use the reasonable and prudent parent standard to create opportunities for participation of the child in age- or developmentally appropriate activities.

202.11(7) Transition planning program. The purpose of the transition planning program is to provide services, supports, activities and referrals to programs that assist children currently or formerly in foster care in acquiring skills and abilities necessary for transition to successful adulthood. The transition planning program offers a life skills assessment, transition plan development, and transition-related services, supports, activities and referrals to programs.

a. *Eligibility.* To be eligible for the transition planning program, a child must be or have been in foster care as defined by rule 441—202.1(234) or 45 Code of Federal Regulations 1355.20 as amended to October 1, 2008, and must meet at least one of the following eligibility requirements:

(1) Is currently in foster care and is 14 years of age or older.

(2) Is under the age of 21 and was adopted from foster care at 16 years of age or older.

(3) Is under the age of 21 and was placed in a subsidized guardianship arrangement from foster care at 16 years of age or older.

(4) Was formerly in foster care and is eligible for and participating in Iowa's aftercare services program as described at 441—Chapter 187.

(5) Was formerly in foster care and is eligible for and participating in Iowa's postsecondary education and training voucher (ETV) program as described at 42 U.S.C. Section 677(a)(6-7).

b. Assessment. A life skills assessment shall be administered to all children in foster care who are aged 14 or older. An assessment shall be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph *"a."* The assessment is designed to evaluate the child's strengths and needs in areas including, but not limited to:

(1) Education,

(2) Physical and mental health,

(3) Employment,

(4) Housing and money management, and

(5) Supportive relationships.

c. Transition plan development. A transition plan shall be completed for all children in foster care who are aged 14 or older, as provided in Iowa Code section 232.2(4)*"f."* Transition plan development shall also be available upon request to any child who has been discharged from foster care but meets the eligibility requirements in paragraph *"a,"* but the transition plan will not be part of a case permanency plan. Transition plan requirements include the following:

(1) The transition plan shall be personalized at the direction of the child and shall be developed in consultation with the child and reviewed by the department in collaboration with a child-centered transition team, honoring the goals and concerns of the child.

(2) The transition plan shall document that the child received and signed a document that describes the rights of the child with respect to education, health, visitation, and court participation. The document must be signed by the child indicating that the child has been provided with a copy of the document and that the rights contained in the document have been explained to the child in an age-appropriate way.

(3) The transition plan shall document that the child received a copy of any credit report pertaining to the child as provided by the child's caseworker on an annual basis until the child is discharged from foster care. The child must receive assistance from the child's caseworker in interpreting and resolving any inaccuracies in the report.

(4) The transition plan shall document that any child leaving foster care at the age of 18 or older was provided with the following documents and information unless the child has been in foster care for less than 30 days or is not eligible to receive such document:

1. An official or certified copy of the child's birth certificate.
2. The child's social security card.
3. A driver's license or identification card issued by the state to the child.
4. Health insurance information.
5. A copy of the child's medical and education records.

(5) The transition plan shall document that the caseworker provided to the child, at the case permanency plan review in the 90 days before the child reached the age of 18, information and education about the importance of having a durable power of attorney for health care and a copy of the state's form used to identify such a proxy. The child has the option to complete the form at the age of 18 or older.

(6) The transition plan shall address the strengths and needs identified in the assessment and detail the services, supports, activities and referrals to programs needed to implement the plan to best assist the child in preparing for successful adulthood. The membership of the transition team and the meeting dates for the team shall be documented in the transition plan.

(7) The transition plan shall be reviewed and updated at each case review after the plan's initial development; within 90 days before the child's eighteenth birthday; and within 90 days before the child is expected to leave foster care if the child remains in care after reaching the age of 18.

d. Transition services. Children shall be offered services, supports, activities and referrals to programs within, but not limited to, the five areas described below according to the child's age and development, strengths and needs, permanency goal, and placement as documented in the case permanency plan.

(1) Education skills increase the child's chances of completing high school or obtaining high school equivalency and of entering a satisfying career. Services may include assistance in academic advising and guidance, secondary and postsecondary educational support, records transfer coordination, tutoring, financial aid planning, career exploration, mentoring, and career advising. Financial assistance for postsecondary education and training may be available to eligible children.

(2) Physical and mental health skills promote healthy physical, mental and emotional functioning. Health education services may include guidance on risk prevention, how to be healthy and fit, how to self-advocate for health care needs and access to health insurance, how to select medical professionals, and how to make informed decisions regarding treatment, lifestyle considerations, spirituality, and recreation. Provision must be made for the child's application for adult services if it is likely the child will need or be eligible for services or other support from the adult service system.

(3) Employment skills enable children to prepare for, seek, and maintain gainful career employment. Services may include employment programs or vocational training, employment search resources, career advising, résumé writing, interview skills, workplace etiquette, and on-the-job training.

(4) Housing and money management skills prepare a child to select, manage, and maintain safe and stable housing. Services may include lessons on the physical maintenance and cleaning of a house and guidance on managing personal finances, such as financial decisions, budgeting, bill paying, use of credit, and financing. Financial assistance for items, including room and board, may be available to children who meet the eligibility criteria of the aftercare services program pursuant to 441—Chapter 187.

(5) Supportive relationships skills promote the healthy development and maintenance of rewarding, lasting relationships. Services may include family support and healthy marriage education, mentoring opportunities, and guidance on how to recognize the needs of others, how to identify and understand personal motivations, how to ensure personal safety, and how to communicate effectively.

[**ARC 7606B**, IAB 3/11/09, effective 5/1/09; **ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 8718B**, IAB 5/5/10, effective 7/1/10; **ARC 0417C**, IAB 10/31/12, effective 1/1/13; **ARC 2069C**, IAB 8/5/15, effective 10/1/15; **ARC 2743C**, IAB 10/12/16, effective 12/1/16]

441—202.12(234) Services to parents.

202.12(1) Child welfare services shall be made available to the parents throughout the period of placement for the purpose of reuniting the family in an agreed-upon time frame. Family safety, risk, and permanency services may be provided to:

a. Promote identification and enhancement of family strengths and protective capacities;

b. Address the factors that resulted in the child's being removed from the family home; and

c. Strengthen family connections to community resources and informal supports.

202.12(2) Placement notification.

a. The parents shall be notified of the location and nature of the child's placement, unless the conditions of this subrule are met.

(1) The department evaluates the situation and determines that notifying the child's parents of the location of the placement would be detrimental to the child's safety and well-being and to the stability of the child's placement due to:

1. Evidence of a direct or indirect threat to harm the foster child or the foster family; or

2. Credible third-party information of a threat of harm to the foster child or the foster family.

(2) The department includes a statement in the child's case permanency plan explaining the decision not to disclose the location of the child to the parents.

b. The decision not to disclose the location of a child's placement shall be reviewed at least every six months when the child's case permanency plan is revised.

202.12(3) The case plan and treatment plan shall specify the services to be provided and the time frame for reuniting the family. These plans shall be developed in cooperation with the parents.

202.12(4) Personal contact shall be made regularly with the parents and the progress towards goal attainment reviewed and documented in the case record. The frequency of the personal contact shall be at least monthly and shall be specified in the child's case permanency plan.

202.12(5) When placement of a breastfeeding child is made, the service worker shall:

a. Assess in consultation with the worker's supervisor whether continued breastfeeding by the mother is in the best interest of the child;

b. Make every reasonable effort to support the mother's continued breastfeeding of the child if determined appropriate; and

c. Document the assessment and efforts in the child's case plan and case notes.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09; **ARC 9961B**, IAB 1/11/12, effective 12/15/11]

441—202.13(234) Removal of the child.

202.13(1) When the department plans to remove a child from a facility, the facility shall be informed in writing of the date of the removal, the reason for the removal, the recourse available to the facility, if any, and that the chapter 17A contested case proceeding is not applicable to the removal. The department shall inform the facility ten days in advance of the removal, except that the facility may be informed less than ten days prior to the removal in the following instances:

a. When the parent or guardian removes the child from voluntary placement.

b. When the court orders removal of a child from placement.

c. When there is evidence of neglect or physical or sexual abuse.

202.13(2) The department may remove a child from a facility when any of the following conditions exist:

a. There is evidence of abuse, neglect, or exploitation of the child.

b. The child needs a specialized service that the facility does not offer.

c. The child is unable to benefit from the placement as evidenced by lack of progress of the child.

d. There is evidence the facility is unable to provide the care needed by the child and fulfill its responsibilities under the case plan.

e. There is lack of cooperation of the facility with the department.

202.13(3) If a foster family objects in writing within seven days from the date that the department furnishes notice of plans to remove the child, the service area manager or designee shall grant a conference to the foster family to determine whether the removal is in the child's best interest.

a. This conference shall not be construed to be a contested case under the Iowa administrative procedure Act, Iowa Code chapter 17A.

b. The conference shall be provided before the child is removed except in instances listed in 202.13(1)*"a"* to *"c."* The service area manager or designee shall review the propriety of the removal and explain the decision to the foster family.

c. The service area manager or designee, on finding that the removal is not in the child's best interests, may overrule the removal decision unless a court order or parental decision prevents the department from doing so.

202.13(4) When the facility requests a child be removed from its care, it shall give a minimum of ten days' notice to the department so planning may be made on behalf of the child.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

[**ARC 8010B**, IAB 7/29/09, effective 10/1/09]

441—202.14(234) Termination. The foster care services shall be terminated when the child is no longer an eligible child, or when the attainment of goals in the case plan has been achieved, or when the goals for whatever reasons cannot be achieved, or when it is evident that the family or individual is unable to benefit from the service or unwilling to accept further services.

This rule is intended to implement Iowa Code section 234.6(6)*"b."*

441—202.15(234) Case permanency plan.

202.15(1) The department worker shall ensure that a case permanency plan is developed for each child who is placed in foster care if the department has agreed to provide foster care through a voluntary placement agreement, if a court has transferred custody or guardianship to the department for the purpose

of foster care, or if a court has placed the child in foster care and ordered the department to supervise the placement.

202.15(2) The department worker shall develop the case permanency plan with the child's parents, unless the child's parents are unwilling to participate in the plan's development, and with the child, unless the child is unable or unwilling to participate. For a child 14 years of age or older in foster care, the case permanency plan must be developed in consultation with the child. The child may choose up to two members of the case planning team who are not the child's foster parent or caseworker. The department may reject an individual selected by a child at any time if the department has good cause to believe the individual would not act in the best interests of the child. One individual selected by the child to be a member of a child's case planning team may be designated to be the child's advisor and, as necessary, advocate with respect to the use of the reasonable and prudent parent standard.

202.15(3) The department worker shall be responsible for ensuring the development of the case permanency plan within the time frames specified in rule 441—130.7(234). In all cases, the case permanency plan shall be completed within 60 days of the date the child entered foster care.

202.15(4) Copies of the initial and subsequent case permanency plans shall be provided to the child, the child's parents, and the foster care provider. Copies shall also be provided to the following, if involved in services to the child: the juvenile court officer, the judge, the child's attorney, the child's guardian ad litem, the child's guardian, the child's custodian, the child's court-appointed special advocate, the parents' attorneys, the county attorney, the state foster care review board, and any other interested parties identified in the plan.

202.15(5) The initial and subsequent case permanency plans shall be completed on the forms specified in rule 441—130.7(234).

202.15(6) Rescinded IAB 4/28/04, effective 6/2/04.

[**ARC 2069C**, IAB 8/5/15, effective 10/1/15]

441—202.16(135H) Department approval of need for a psychiatric medical institution for children.

202.16(1) Applicants for departmental approval of need shall submit the following to the division of child and family services:

a. A description of the population to be served, including age, sex, and types of disorders, and an estimate of the number of these youth in need of psychiatric care in the area of the state in which the applicant is located.

b. A statement of the number of beds requested and a description of the treatment program to be provided, the outcomes to be achieved and the techniques for measuring outcomes.

c. A proposed date of operation as a psychiatric medical institution for children.

d. A description of the applicant's experience with providing similar services to youth, especially the target population.

e. A description of the applicant's plan, including the timeline for achieving accreditation to provide psychiatric services from a federally recognized accrediting organization under the organization's standards for residential settings and licensure as a psychiatric medical institution for children, or a copy of the organization's report if already accredited.

f. References from the service area manager for the department service area in which the proposed psychiatric medical institution for children would be located, the chief juvenile court officer of the judicial district in which the proposed psychiatric medical institution for children would be located and the applicant's licensor from the department of inspections and appeals or department of public health.

202.16(2) The department shall evaluate proposals and issue a decision based on the following criteria:

a. The number of psychiatric medical institutions for children beds for the proposed population which are needed in the area of the state in which the facility would be located, based on the department's most recent needs assessment.

b. The steps the facility has taken towards achieving accreditation from a federally recognized accrediting organization and licensure as a psychiatric medical institution for children.

c. The applicant's ability to provide services and support consistent with the requirements under Iowa Code chapter 232 including, but not limited to, evidence that:

(1) Children will be served in a setting which is in close proximity to their parents' home.

(2) Each child will receive services consistent with the child's best interests and special psychiatric needs as identified in the child's case permanency plan.

(3) Children and their families will receive services to facilitate the children's return home or other permanent placement.

d. The applicant's ability to provide children with a non-hospital-type living environment if the applicant is not freestanding from a hospital or health care facility.

e. The limits on the number of beds found in Iowa Code section 135H.6, subsection 5.

202.16(3) If a facility has not been licensed as a psychiatric medical institution for children within one year after the date of the department's approval of need, the department's approval shall expire unless the department has approved an extension. An extension may be approved up to a maximum of six months if the agency has documented extenuating circumstances which prevented completion of the licensing process.

This rule is intended to implement Iowa Code section 135H.6.

441—202.17(232) Area group care targets.

202.17(1) *Area target.* A group care budget target shall be established for each departmental service area, which shall be based on the annual statewide group care appropriation established by the general assembly.

a. The department and the judicial branch shall jointly develop a formula for allocating the group care appropriation among the departmental service areas. The formula shall be based on:

(1) Proportional child population.

(2) Proportional group foster care usage in the previous five completed fiscal years.

(3) Other indicators of need.

b. Any portion of the group care appropriation allocated for 50 highly structured juvenile program beds and not used may be used for group care.

c. Upon written agreement of the affected service area managers and chief juvenile court officers, service areas may transfer part of their group care budget from one service area to another. A service area may exceed its budget target figure up to 5 percent during the fiscal year, providing that the overall funding allocation by the department for all child welfare services in the service area is not exceeded.

d. Notwithstanding the statewide appropriation established in this subrule, a budget established in a service area's group care plan pursuant to Iowa Code section 232.143 may be exceeded, a group care placement may be ordered, and state payment may be made if the review organization finds that the placement is necessary to meet the child's service needs and if the service area has additional funds transferred from another service area or if the service area is within 5 percent of its group care budget target figure pursuant to 441—paragraph 202.17(1)*"c."*

The department and juvenile court services shall work together to ensure that a service area's group care expenditures shall not exceed the funds allocated to the service area for group care in the fiscal year.

e. If at any time after September 30, 1998, annualization of a service area's current expenditures indicates a service area is at risk of exceeding its group foster care expenditure target under Iowa Code section 232.143 by more than 5 percent, the department and juvenile court services shall examine all group foster care placements in that service area in order to identify those which might be appropriate for termination. In addition, any aftercare services believed to be needed for the children whose placements may be terminated shall be identified.

The department and juvenile court services shall initiate action to set dispositional review hearings for the placements identified. In the dispositional review hearing, the juvenile court shall determine whether needed aftercare services are available and whether termination of the placement is in the best interest of the child and the community.

202.17(2) *Plan for achieving target.* For each of the departmental service areas, representatives appointed by the department and juvenile court services shall establish a plan for containing the

expenditure for children placed in group care within the budget target allocated to that service area. The plan shall include monthly targets and strategies for developing alternatives to group care placements.

The plans shall also ensure potential group care referrals are reviewed by the review organization prior to submission of a recommendation for group care placement to the court.

Each area plan shall be established in advance of the fiscal year to which the plan applies. To the extent possible, the department and the juvenile court shall coordinate the planning required under this subrule with planning for services paid under Iowa Code section 232.141, subsection 4. The department's service area manager shall communicate regularly, as specified in the area plan, with the juvenile courts within the service area concerning the current status of the plan's implementation.

This rule is intended to implement Iowa Code section 232.143.

441—202.18(235) Local transition committees. Local transition committees shall be established in each of the department service areas. The service area manager or designee shall determine the number of local transition committees needed within the service area, set operating policies and procedures, and appoint committee membership.

202.18(1) *Purpose.* The purpose of local transition committees, as established by Iowa Code Supplement section 235.7, is to ensure that the transition needs of youth in foster care who are 16 years of age or older have been addressed in order to assist the youth in preparing for the transition from foster care to adulthood.

202.18(2) *Membership.* Each committee shall have a designated number of members.

a. The standing committee membership may include, but is not limited to:

(1) Department staff involved with child welfare, adult services, or transition planning.

(2) Juvenile court services staff.

(3) Adult service system staff.

(4) Education staff.

(5) Service care provider representation.

(6) Others knowledgeable about community resources.

b. Additionally, nonstanding membership may include those knowledgeable about the youth, including the child's court-appointed special advocate, guardian ad litem, and service or care providers.

c. In areas where teams or boards already in existence are involved in review and planning for youth needs, such as the foster care review board or child welfare funding decategorization boards, such teams or boards may serve as local transition committees.

202.18(3) *Duties.* Local transition committees shall address the transition needs of youth in foster care who are 16 years of age or older and who have a case permanency plan as defined in Iowa Code Supplement section 232.2. Each committee shall have operating policies and procedures to carry out the duties below.

a. Each committee shall establish a process for review and approval of written transition plans for youth for whom the committee has placement responsibility that meets a continuum of case needs and coordinates with local transition planning protocol. The process may include a paper review or an in-person review, or both, according to case need.

b. The committee may be involved when the youth is at least 16 years of age, but shall be involved in reviewing and approving a youth's transition plan before the youth reaches age 17½. When a youth enters foster care at age 17½ or older, the committee shall be involved in reviewing and approving the youth's transition plan within 30 days of completion.

c. In reviewing a youth's transition plan, the committee shall identify and act to address gaps existing in services or supports available that would assist the youth in the transition from foster care to adulthood.

d. For those youth expected to need services as adults, the committee shall ensure that the transition plan was developed with the participation of any person reasonably expected to be a service provider when the youth becomes an adult or to become responsible for the costs of services at that time.

e. The committee shall ensure that transition planning and review is coordinated with overall case planning and review. Committee review and approval shall be indicated in the youth's case permanency plan.

f. With respect to meetings involving a specific youth receiving foster care and the youth's family, the local transition committees are not subject to Iowa Code chapter 21.

g. The information and records of or provided to a local transition committee regarding a youth receiving foster care and the youth's family are not public records pursuant to Iowa Code chapter 22 when the records relate to the foster care placement and transition needs of the youth.

h. Members of the committees are subject to the standards of confidentiality set forth in Iowa Code sections 600.16, 217.30 and 235A.15.

202.18(4) *Report.* The service area manager or designee shall submit a report on transition planning committees to the department's division of child and family services. The report shall be submitted annually by October 1 for the immediately preceding fiscal year. The report shall include, but not be limited to, the following:

a. The geographical area covered for each committee within the service area.

b. Standing committee membership for each committee.

c. The number of cases reviewed by each committee.

d. Identification of barriers to successful transition and gaps in community services or supports.

e. Suggestions for ways to transition youth from foster care to adulthood more effectively.

This rule is intended to implement Iowa Code Supplement section 235.7.

[Filed 9/28/77, Notice 8/10/77—published 10/19/77, effective 11/23/77]
[Filed 9/6/79, Notice 6/27/79—published 10/3/79, effective 11/7/79]
[Filed 10/23/80, Notice 9/3/80—published 11/12/80, effective 12/17/80]
[Filed 11/5/82, Notice 9/15/82—published 11/24/82, effective 1/1/83]
[Filed 3/25/83, Notices 9/29/82, 11/24/82—published 4/13/83, effective 7/1/83]
[Filed 10/28/83, Notice 9/14/83—published 11/23/83, effective 1/1/84]
[Filed 11/18/83, Notice 10/12/83—published 12/7/83, effective 2/1/84]
[Filed emergency 2/10/84—published 2/29/84, effective 2/10/84]
[Filed 4/2/84, Notice 2/1/84—published 4/25/84, effective 6/1/84]
[Filed emergency 8/31/84—published 9/26/84, effective 10/1/84]
[Filed emergency 6/14/85—published 7/3/85, effective 7/1/85]
[Filed 8/23/85, Notice 7/3/85—published 9/11/85, effective 11/1/85]
[Filed emergency 1/15/87—published 2/11/87, effective 1/15/87]
[Filed 3/3/87, Notice 12/31/86—published 3/25/87, effective 5/1/87]
[Filed emergency 6/19/87—published 7/15/87, effective 7/1/87]
[Filed 8/28/87, Notice 7/15/87—published 9/23/87, effective 11/1/87]
[Filed 9/24/87, Notice 8/12/87—published 10/21/87, effective 12/1/87]
[Filed 11/25/87, Notice 10/7/87—published 12/16/87, effective 2/1/88]
[Filed 4/22/88, Notice 2/10/88—published 5/18/88, effective 7/1/88]
[Filed 5/12/89, Notice 2/8/89—published 5/31/89, effective 8/1/89]
[Filed emergency 6/8/89—published 6/28/89, effective 7/1/89]
[Filed 7/14/89, Notice 4/19/89—published 8/9/89, effective 10/1/89]
[Filed 8/17/89, Notice 6/28/89—published 9/6/89, effective 10/11/89]
[Filed 9/15/89, Notice 7/26/89—published 10/4/89, effective 12/1/89]
[Filed 5/17/91, Notice 4/3/91—published 6/12/91, effective 8/1/91]
[Filed 9/18/91, Notice 7/10/91—published 10/16/91, effective 12/1/91]
[Filed 12/11/91, Notice 10/16/91—published 1/8/92, effective 3/1/92][1]
[Filed 2/13/92, Notice 1/8/92—published 3/4/92, effective 5/1/92]
[Filed emergency 4/15/92—published 5/13/92, effective 4/16/92]
[Filed emergency 6/12/92—published 7/8/92, effective 7/1/92]
[Filed 8/14/92, Notices 5/27/92, 7/8/92—published 9/2/92, effective 11/1/92]
[Filed emergency 6/11/93—published 7/7/93, effective 7/1/93]

[Filed without Notice 8/12/93—published 9/1/93, effective 11/1/93]
[Filed 8/12/93, Notices 2/17/93, 7/7/93—published 9/1/93, effective 11/1/93]
[Filed 12/16/93, Notice 9/1/93—published 1/5/94, effective 3/1/94]
[Filed emergency 5/11/94 after Notice 3/16/94—published 6/8/94, effective 6/1/94]
[Filed emergency 6/16/94—published 7/6/94, effective 7/1/94]
[Filed 8/12/94, Notice 7/6/94—published 8/31/94, effective 11/1/94]
[Filed 3/20/95, Notice 1/18/95—published 4/12/95, effective 6/1/95]
[Filed emergency 6/7/95—published 7/5/95, effective 7/1/95]
[Filed 8/10/95, Notice 7/5/95—published 8/30/95, effective 11/1/95]
[Filed 12/12/95, Notice 10/25/95—published 1/3/96, effective 3/1/96]
[Filed emergency 6/13/96—published 7/3/96, effective 7/1/96]
[Filed 8/15/96, Notice 7/3/96—published 9/11/96, effective 11/1/96]
[Filed emergency 6/12/97—published 7/2/97, effective 7/1/97]
[Filed 8/13/97, Notice 7/2/97—published 9/10/97, effective 11/1/97]
[Filed emergency 6/10/98—published 7/1/98, effective 7/1/98]
[Filed without Notice 6/10/98—published 7/1/98, effective 8/15/98]
[Filed 8/12/98, Notice 7/1/98—published 9/9/98, effective 11/1/98]
[Filed 8/12/99, Notice 6/30/99—published 9/8/99, effective 11/1/99]
[Filed 9/12/00, Notice 7/26/00—published 10/4/00, effective 12/1/00]
[Filed emergency 7/10/03—published 8/6/03, effective 7/10/03]
[Filed 10/10/03, Notice 8/6/03—published 10/29/03, effective 1/1/04]
[Filed 3/11/04, Notice 1/21/04—published 3/31/04, effective 6/1/04]
[Filed 4/9/04, Notice 2/18/04—published 4/28/04, effective 6/2/04]
[Filed 11/16/05, Notice 9/28/05—published 12/7/05, effective 1/11/06]
[Filed emergency 10/12/06—published 11/8/06, effective 11/1/06]
[Filed emergency 12/13/06 after Notice 11/8/06—published 1/3/07, effective 1/1/07]
[Filed 3/14/07, Notice 8/30/06—published 4/11/07, effective 7/1/07]
[Filed 2/13/08, Notice 12/19/07—published 3/12/08, effective 5/1/08]
[Filed 9/17/08, Notice 7/2/08—published 10/8/08, effective 12/1/08]
[Filed ARC 7606B (Notice ARC 7372B, IAB 12/3/08), IAB 3/11/09, effective 5/1/09]
[Filed ARC 8010B (Notice ARC 7712B, IAB 4/8/09), IAB 7/29/09, effective 10/1/09]
[Filed ARC 8718B (Notice ARC 8537B, IAB 2/24/10), IAB 5/5/10, effective 7/1/10]
[Filed Emergency After Notice ARC 9961B (Notice ARC 9776B, IAB 10/5/11), IAB 1/11/12, effective 12/15/11]
[Filed ARC 0417C (Notice ARC 0257C, IAB 8/8/12), IAB 10/31/12, effective 1/1/13]
[Filed ARC 2069C (Notice ARC 1997C, IAB 5/27/15), IAB 8/5/15, effective 10/1/15]
[Filed ARC 2342C (Notice ARC 2124C, IAB 9/2/15), IAB 1/6/16, effective 2/10/16]
[Filed ARC 2743C (Notice ARC 2652C, IAB 8/3/16), IAB 10/12/16, effective 12/1/16]
[Filed ARC 2885C (Notice ARC 2771C, IAB 10/12/16), IAB 1/4/17, effective 3/1/17]
[Filed ARC 3185C (Notice ARC 3040C, IAB 4/26/17), IAB 7/5/17, effective 9/1/17]

[1] 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.

INSPECTIONS AND APPEALS DEPARTMENT[481]

CHAPTER 1
ADMINISTRATION

1.1(10A) Organization
1.2(10A) Definitions
1.3(10A) Administration division
1.4(10A) Investigations division
1.5(10A) Health facilities division
1.6(10A) Administrative hearings division
1.7(10A) Administering discretion
1.8(10A) Employment appeal board
1.9(10A,237) Child advocacy board
1.10(10A,13B) State public defender
1.11(10A,99D,99F) Racing and gaming commission

CHAPTER 2
PETITIONS FOR RULE MAKING

2.1(17A) Petition for rule making
2.2(17A) Briefs
2.3(17A) Inquiries
2.4(17A) Agency consideration

CHAPTER 3
DECLARATORY ORDERS
(Uniform Rules)

3.1(17A) Petition for declaratory order
3.2(17A) Notice of petition
3.3(17A) Intervention
3.4(17A) Briefs
3.5(17A) Inquiries
3.6(17A) Service and filing of petitions and other papers
3.7(17A) Consideration
3.8(17A) Action on petition
3.9(17A) Refusal to issue order
3.12(17A) Effect of a declaratory order

CHAPTER 4
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

4.3(17A) Public rule-making docket
4.4(17A) Notice of proposed rule making
4.5(17A) Public participation
4.6(17A) Regulatory analysis
4.10(17A) Exemptions from public rule-making procedures
4.11(17A) Concise statement of reasons
4.13(17A) Agency rule-making record

CHAPTER 5
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

5.1(17A,22) Definitions
5.3(17A,22) Requests for access to records

5.6(17A,22) Procedure by which a subject may have additions, dissents, or objections entered into the record
5.9(17A,22) Disclosures without the consent of the subject
5.10(17A,22) Routine use
5.11(17A,22) Consensual disclosure of confidential records
5.12(17A,22) Release to subject
5.13(17A,22) Availability of records
5.14(17A,22) Authority to release confidential records
5.15(17A,22) Personnel files
5.16(17A,22) Personally identifiable information

CHAPTER 6
UNIFORM WAIVER AND VARIANCE RULES

6.1(10A,17A,ExecOrd11) Applicability
6.2(10A,17A,ExecOrd11) Definitions
6.3(10A,17A,ExecOrd11) Interpretive rules
6.4(10A,17A,ExecOrd11) Compliance with statute
6.5(10A,17A,ExecOrd11) Criteria for waiver or variance
6.6(10A,17A,ExecOrd11) Filing of petition
6.7(10A,17A,ExecOrd11) Content of petition
6.8(10A,17A,ExecOrd11) Additional information
6.9(10A,17A,ExecOrd11) Notice
6.10(10A,17A,ExecOrd11) Hearing procedures
6.11(10A,17A,ExecOrd11) Ruling
6.12(10A,17A,ExecOrd11) Public availability
6.13(10A,17A,ExecOrd11) Voiding or cancellation
6.14(10A,17A,ExecOrd11) Violations
6.15(10A,17A,ExecOrd11) Defense
6.16(10A,17A,ExecOrd11) Appeals
6.17(10A,17A,ExecOrd11) Sample petition for waiver or variance

CHAPTER 7
CONSENT FOR THE SALE OF GOODS
AND SERVICES

7.1(68B) General prohibition
7.2(68B) Definitions
7.3(68B) Conditions of consent for officials
7.4(68B) Application for consent
7.5(68B) Effect of consent
7.6(22,68B) Public information
7.7(68B) Appeal

CHAPTER 8
LICENSING ACTIONS FOR NONPAYMENT OF CHILD SUPPORT
AND STUDENT LOAN DEFAULT/NONCOMPLIANCE
WITH AGREEMENT FOR PAYMENT OF OBLIGATION

8.1(252J) Certificates of noncompliance
8.2(261) Student loan default/noncompliance with agreement for payment of obligation
8.3(261) Suspension or revocation of a license

CHAPTER 9
Reserved

CHAPTER 10
CONTESTED CASE HEARINGS

10.1(10A) Definitions
10.2(10A,17A) Time requirements
10.3(10A) Requests for a contested case hearing
10.4(10A) Transmission of contested cases
10.5(17A) Notices of hearing
10.6(10A) Waiver of procedures
10.7(10A,17A) Telephone proceedings
10.8(10A,17A) Scheduling
10.9(17A) Disqualification
10.10(10A,17A) Consolidation—severance
10.11(10A,17A) Pleadings
10.12(17A) Service and filing of documents
10.13(17A) Discovery
10.14(10A,17A) Subpoenas
10.15(10A,17A) Motions
10.16(17A) Prehearing conference
10.17(10A) Continuances
10.18(10A,17A) Withdrawals
10.19(10A,17A) Intervention
10.20(17A) Hearing procedures
10.21(17A) Evidence
10.22(17A) Default
10.23(17A) Ex parte communication
10.24(10A,17A) Decisions
10.25(10A,17A) DIA appeals
10.26(10A,17A,272C) Board hearings
10.27(10A) Transportation hearing fees
10.28(10A) Recording costs
10.29(10A) Code of administrative judicial conduct

CHAPTER 11
PROCEDURE FOR CONTESTED CASES INVOLVING PERMITS TO CARRY WEAPONS AND ACQUIRE FIREARMS

11.1(17A,724) Definitions
11.2(724) Appeals
11.3(17A,724) Notice of hearing
11.4(17A,724) Agency record
11.5(17A) Contested case hearing
11.6(17A) Service and filing of documents
11.7(17A) Witness lists and exhibits
11.8(17A) Evidence
11.9(17A) Withdrawals and dismissals
11.10(17A) Default
11.11(10A) Costs
11.12(724) Probable cause
11.13(724) Clear and convincing evidence
11.14(17A) Rehearing

CHAPTERS 12 to 19
Reserved

AUDITS DIVISION

CHAPTERS 20 and 21
Reserved

CHAPTER 22
HEALTH CARE FACILITY AUDITS

22.1(10A) Audit occurrence
22.2(10A) Confidentiality

CHAPTERS 23 and 24
Reserved

CHAPTER 25
IOWA TARGETED SMALL BUSINESS CERTIFICATION PROGRAM

25.1(73) Definitions
25.2(10A) Certification
25.3(17A) Description of application
25.4(10A) Eligibility standards
25.5(10A) Special consideration
25.6(10A) Family-owned business
25.7(10A) Cottage industry
25.8(10A) Decertification
25.9(12) Request for bond waiver
25.10(714) Fraudulent practices in connection with targeted small business programs
25.11(17A) Appeal procedure

CHAPTERS 26 to 29
Reserved

INSPECTIONS DIVISION

CHAPTER 30
FOOD AND CONSUMER SAFETY

30.1(10A,137C,137D,137F) Food and consumer safety bureau
30.2(10A,137C,137D,137F) Definitions
30.3(137C,137D,137F) Licensing and postings
30.4(137C,137D,137F) License fees
30.5(137F) Penalty and delinquent fees
30.6(137C,137D,137F) Returned checks
30.7(137F) Double licenses
30.8(137C,137D,137F) Inspection frequency
30.9(22) Examination of records
30.10(17A,137C,137D,137F) Denial, suspension, or revocation of a license to operate
30.11(10A,137C,137D,137F) Formal hearing
30.12(137F) Primary servicing laboratory

CHAPTER 31
FOOD ESTABLISHMENT AND FOOD
PROCESSING PLANT INSPECTIONS

31.1(137F) Inspection standards for food establishments.[2]
31.2(137F) Inspection standards for food processing plants
31.3(137D,137F) Adulterated food and disposal

31.4(137D,137F) False label or defacement
31.5(137F) Temporary food establishments and farmers market potentially hazardous food licensees

CHAPTERS 32 and 33
Reserved

CHAPTER 34
HOME BAKERIES

34.1(137D) Inspection standards
34.2(137D) Enforcement
34.3(137D) Labeling requirement
34.4(137D) Annual gross sales
34.5(137D) Criminal offense—conviction of license holder

CHAPTER 35
CONTRACTOR REQUIREMENTS

35.1(137C,137D,137F) Definitions
35.2(137C,137D,137F) Contracts
35.3(137C,137D,137F) Contractor
35.4(137C,137D,137F) Contractor inspection personnel
35.5(137C,137D,137F) Investigation
35.6(137C,137D,137F) Inspection standards
35.7(137C,137D,137F) Enforcement
35.8(137C,137D,137F) Licensing
35.9(137C,137D,137F) Records
35.10(137C,137D,137F) Reporting requirements
35.11(137C,137D,137F) Contract rescinded

CHAPTER 36
Reserved

CHAPTER 37
HOTEL AND MOTEL INSPECTIONS

37.1(137C) Building and grounds
37.2(137C) Guest rooms
37.3(137C) Bedding
37.4(137C) Lavatory facilities
37.5(137C) Glasses and ice
37.6(137C) Employees
37.7(137C) Room rates
37.8(137C) Inspections
37.9(137C) Enforcement
37.10(137C) Criminal offense—conviction of license holder

CHAPTERS 38 and 39
Reserved

CHAPTER 40
FOSTER CARE FACILITY INSPECTIONS

40.1(10A) License surveys
40.2(10A) Unannounced inspections
40.3(10A) Results
40.4(10A) Ownership of records

CHAPTER 41
PSYCHIATRIC MEDICAL INSTITUTIONS FOR CHILDREN (PMIC)

41.1(135H) Definitions
41.2(135H) Application for license
41.3(135H) Renewal application or change of ownership
41.4(135H) Licenses for distinct parts
41.5(135H) Variances
41.6(135H) Notice to the department
41.7(135H) Inspection of complaints
41.8(135H) General requirement
41.9(135H) Certification of need for services
41.10(135H) Active treatment
41.11(135H) Individual plan of care
41.12(135H) Individual written plan of care
41.13(135H) Plan of care team
41.14(135H) Required discharge
41.15(135H) Criminal behavior involving children
41.16(22,135H) Confidential or open information
41.17(135H) Additional provisions concerning physical restraint

CHAPTERS 42 to 49
Reserved

CHAPTER 50
HEALTH CARE FACILITIES ADMINISTRATION

50.1(10A) Inspections
50.2(10A) Definitions
50.3(135B,135C) Licensing
50.4(135C) Fines and citations
50.5(135C) Denial, suspension or revocation
50.6(10A) Formal hearing
50.7(10A,135C) Additional notification
50.8(22,135B,135C) Records
50.9(135C) Criminal, dependent adult abuse, and child abuse record checks
50.10(135C) Inspections, exit interviews, plans of correction, and revisits
50.11(135C) Complaint and self-reported incident investigation procedure
50.12(135C) Requirements for service
50.13(135C) Inspectors' conflicts of interest

CHAPTER 51
HOSPITALS

51.1(135B) Definitions
51.2(135B) Classification, compliance and license
51.3(135B) Quality improvement program
51.4(135B) Long-term acute care hospital located within a general hospital
51.5(135B) Medical staff
51.6(135B) Patient rights and responsibilities
51.7(135B) Abuse
51.8(135B) Organ, tissue and eye procurement
51.9(135B) Nursing services
51.10 and 51.11 Reserved
51.12(135B) Records and reports
51.13 Reserved

51.14(135B) Pharmaceutical service
51.15(135B) Orders other than medication
51.16(135B) Radiological services
51.17 Reserved
51.18(135B) Laboratory service
51.19 Reserved
51.20(135B) Food and nutrition services
51.21 Reserved
51.22(135B) Equipment for patient care
51.23 Reserved
51.24(135B) Infection control
51.25 Reserved
51.26(135B) Surgical services
51.27 Reserved
51.28(135B) Anesthesia services
51.29 Reserved
51.30(135B) Emergency services
51.31 Reserved
51.32(135B) Obstetric and neonatal services
51.33 Reserved
51.34(135B) Pediatric services
51.35 Reserved
51.36(135B) Psychiatric services
51.37 Reserved
51.38(135B) Long-term care service
51.39(135B) Penalty and enforcement
51.40 Reserved
51.41(135B) Criminal, dependent adult abuse, and child abuse record checks
51.42 to 51.49 Reserved
51.50(135B) Minimum standards for construction
51.51 and 51.52 Reserved
51.53(135B) Critical access hospitals

CHAPTER 52
DEPENDENT ADULT ABUSE IN FACILITIES AND PROGRAMS

52.1(235E) Definitions
52.2(235E) Persons who must report dependent adult abuse and the reporting procedure for those persons
52.3(235E) Reports and registry of dependent adult abuse
52.4(235E) Financial institution employees and reporting suspected financial exploitation
52.5(235E) Evaluation of report
52.6(235E) Separation of victim and alleged abuser
52.7(235E) Interviews, examination of evidence, and investigation of dependent adult abuse allegations
52.8(235E) Notification to subsequent employers

CHAPTER 53
HOSPICE LICENSE STANDARDS

53.1(135J) Definitions
53.2(135J) License
53.3(135J) Patient rights
53.4(135J) Governing body

53.5(135J) Quality assurance and utilization review
53.6(135J) Attending physician services
53.7(135J) Medical director
53.8(135J) Interdisciplinary team (IDT)
53.9(135J) Nursing services
53.10 Reserved
53.11(135J) Coordinator of patient care
53.12(135J) Social services
53.13(135J) Counseling services
53.14(135J) Volunteer services
53.15(135J) Spiritual counseling
53.16(135J) Optional services
53.17(135J) Contracted services
53.18(135J) Short-term hospital services
53.19(135J) Bereavement services
53.20(135J) Records

CHAPTER 54
GOVERNOR'S AWARD FOR QUALITY CARE

54.1(135C) Purpose
54.2(135C) Definitions
54.3(135C) Nomination
54.4(135C) Applicant eligibility
54.5(135C) Nomination information
54.6(135C) Evaluation
54.7(135C) Selection of finalists
54.8(135C) Certificate of recognition

CHAPTER 55
Reserved

CHAPTER 56
FINING AND CITATIONS

56.1(135C) Authority for citations
56.2(135C) Classification of violations—classes
56.3(135C) Fines
56.4(135C) Time for compliance
56.5(135C) Failure to correct a violation within the time specified—penalty
56.6(135C) Treble and double fines
56.7(135C) Notation of classes of violations
56.8(135C) Notation for more than one class of violation
56.9(135C) Factors determining selection of class of violation
56.10(135C) Factors determining imposition of citation and fine
56.11(135C) Class I violation not specified in the rules
56.12(135C) Class I violation as a result of multiple lesser violations
56.13(135C) Form of citations
56.14(135C) Licensee's response to a citation
56.15(135C) Informal conference
56.16(135C) Procedure for facility after informal conference
56.17(135C) Formal contest

CHAPTER 57
RESIDENTIAL CARE FACILITIES

57.1(135C)	Definitions
57.2(135C,17A)	Waiver or variance
57.3(135C)	Application for licensure
57.4(135C)	Issuance of license
57.5(135C)	Licenses for distinct parts
57.6(135C)	Special classification—memory care
57.7(135C)	General requirements
57.8(135C)	Certified volunteer long-term care ombudsman program
57.9(135C)	Required notifications to the department
57.10(135C)	Administrator
57.11(135C)	Personnel
57.12(135C)	General policies
57.13(135C)	Admission, transfer and discharge
57.14(135C)	Involuntary discharge or transfer
57.15(135C)	Residency agreement
57.16(135C)	Medical examinations
57.17(135C)	Records
57.18(135C)	Resident care and personal services
57.19(135C)	Drugs
57.20(135C)	Dental services
57.21(135C)	Dietary
57.22(135C)	Orientation and service plan
57.23(135C)	Resident activities program
57.24(135C)	Residents' rights
57.25(135C)	Dignity preserved
57.26(135C)	Communications
57.27(135C)	Resident activities
57.28(135C)	Resident property
57.29(135C)	Financial affairs—management
57.30(135C)	Resident work
57.31(135C)	Family—shared rooms
57.32(135C)	Resident abuse prohibited
57.33(135C)	Crisis intervention
57.34(135C)	Safety
57.35(135C)	Housekeeping
57.36(135C)	Maintenance
57.37(135C)	Laundry
57.38(135C)	Garbage and waste disposal
57.39(135C)	Supplies
57.40(135C)	Buildings, furnishings, and equipment
57.41(135C)	Family and employee accommodations
57.42(135C)	Animals
57.43(135C)	Another business or activity in a facility
57.44(135C)	Respite care services

CHAPTER 58
NURSING FACILITIES

58.1(135C)	Definitions
58.2(135C)	Variances
58.3(135C)	Application for licensure

58.4(135C)	General requirements
58.5(135C)	Notifications required by the department
58.6	Reserved
58.7(135C)	Licenses for distinct parts
58.8(135C)	Administrator
58.9(135C)	Administration
58.10(135C)	General policies
58.11(135C)	Personnel
58.12(135C)	Admission, transfer, and discharge
58.13(135C)	Contracts
58.14(135C)	Medical services
58.15(135C)	Records
58.16(135C)	Resident care and personal services
58.17	Reserved
58.18(135C)	Nursing care
58.19(135C)	Required nursing services for residents
58.20(135C)	Duties of health service supervisor
58.21(135C)	Drugs, storage, and handling
58.22(135C)	Rehabilitative services
58.23(135C)	Dental, diagnostic, and other services
58.24(135C)	Dietary
58.25(135C)	Social services program
58.26(135C)	Resident activities program
58.27(135C)	Certified volunteer long-term care ombudsman program
58.28(135C)	Safety
58.29(135C)	Resident care
58.30	Reserved
58.31(135C)	Housekeeping
58.32(135C)	Maintenance
58.33(135C)	Laundry
58.34(135C)	Garbage and waste disposal
58.35(135C)	Buildings, furnishings, and equipment
58.36(135C)	Family and employee accommodations
58.37(135C)	Animals
58.38(135C)	Supplies
58.39(135C)	Residents' rights in general
58.40(135C)	Involuntary discharge or transfer
58.41(135C)	Residents' rights
58.42(135C)	Financial affairs—management
58.43(135C)	Resident abuse prohibited
58.44(135C)	Resident records
58.45(135C)	Dignity preserved
58.46(135C)	Resident work
58.47(135C)	Communications
58.48(135C)	Resident activities
58.49(135C)	Resident property
58.50(135C)	Family visits
58.51(135C)	Choice of physician and pharmacy
58.52(135C)	Incompetent resident
58.53(135C)	County care facilities
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)

58.55(135C) Another business or activity in a facility
58.56(135C) Respite care services
58.57(135C) Training of inspectors

CHAPTER 59
TUBERCULOSIS (TB) SCREENING

59.1(135B,135C) Purpose
59.2(135B,135C) Definitions
59.3(135B,135C) TB risk assessment
59.4(135B,135C) Health care facility or hospital risk classification
59.5(135B,135C) Baseline TB screening procedures for health care facilities and hospitals
59.6(135B,135C) Serial TB screening procedures for health care facilities and hospitals
59.7(135B,135C) Screening of HCWs who transfer to other health care facilities or hospitals
59.8(135B,135C) Baseline TB screening procedures for residents of health care facilities
59.9(135B,135C) Serial TB screening procedures for residents of health care facilities
59.10(135B,135C) Performance of screening and testing

CHAPTER 60
MINIMUM PHYSICAL STANDARDS
FOR RESIDENTIAL CARE FACILITIES

60.1(135C) Definitions
60.2(135C) Variances
60.3(135C) General requirements
60.4(135C) Typical construction
60.5(135C) Supervised care unit
60.6(135C) Support area
60.7(135C) Service area
60.8(135C) Administration and staff area
60.9(135C) Definition of public area
60.10(135C) Elevator requirements
60.11(135C) Mechanical requirements
60.12(135C) Electrical requirement
60.13(135C) Codes and standards

CHAPTER 61
MINIMUM PHYSICAL STANDARDS FOR NURSING FACILITIES

61.1(135C) Definitions
61.2(135C) General requirements
61.3(135C) Submission of construction documents
61.4(135C) Variances
61.5(135C) Additional notification requirements
61.6(135C) Construction requirements
61.7(135C) Nursing care unit
61.8(135C) Dietetic and other service areas
61.9(135C) Specialized unit or facility for persons with chronic confusion or a dementing illness (CCDI unit or facility)

CHAPTER 62
RESIDENTIAL CARE FACILITIES
FOR PERSONS WITH MENTAL ILLNESS (RCF/PMI)

62.1(135C) Definitions
62.2(135C) Application for license
62.3(135C) Licenses for distinct parts

62.4(135C) Variances
62.5(135C) General requirements
62.6(135C) Notification required by the department
62.7(135C) Administrator
62.8(135C) Administration
62.9(135C) Personnel
62.10(135C) General admission policies
62.11(135C) Evaluation services
62.12(135C) Programming
62.13(135C) Crisis intervention
62.14(135C) Discharge or transfer
62.15(135C) Medication management
62.16(135C) Resident property
62.17(135C) Financial affairs
62.18(135C) Records
62.19(135C) Health and safety
62.20(135C) Nutrition
62.21(135C) Physical facilities and maintenance
62.22 Reserved
62.23(135C) Residents' rights in general
62.24(135C) County care facilities
62.25(135C) Another business or activity in a facility
62.26(135C) Respite care services

CHAPTER 63
RESIDENTIAL CARE FACILITIES FOR THE
INTELLECTUALLY DISABLED

63.1(135C) Definitions
63.2(135C) Variances
63.3(135C) Application for licensure
63.4(135C) General requirements
63.5(135C) Notifications required by the department
63.6 Reserved
63.7(135C) Licenses for distinct parts
63.8(135C) Administrator
63.9(135C) General policies
63.10 Reserved
63.11(135C) Personnel
63.12(135C) Resident care and personal services
63.13(135C) Admission, transfer, and discharge
63.14(135C) Contracts
63.15(135C) Physical examinations
63.16(135C) Dental services
63.17(135C) Records
63.18(135C) Drugs
63.19(135C) Dietary
63.20(135C) Orientation program
63.21(135C) Individualized program of care
63.22 Reserved
63.23(135C) Safety
63.24(135C) Housekeeping
63.25(135C) Maintenance

63.26(135C) Laundry
63.27(135C) Garbage and waste disposal
63.28(135C) Buildings, furnishings, and equipment
63.29(135C) Family and employee accommodations
63.30(135C) Animals
63.31(135C) Environment and grounds
63.32(135C) Supplies
63.33(135C) Residents' rights in general
63.34(135C) Involuntary discharge or transfer
63.35(135C) Resident rights
63.36(135C) Financial affairs—management
63.37(135C) Resident abuse prohibited
63.38(135C) Resident records
63.39(135C) Dignity preserved
63.40(135C) Resident work
63.41(135C) Communications
63.42(135C) Resident activities
63.43(135C) Resident property
63.44(135C) Family visits
63.45(135C) Choice of physician
63.46(135C) Incompetent resident
63.47(135C) Specialized license for three- to five-bed facilities
63.48 Reserved
63.49(135C) Another business or activity in a facility
63.50(135C) Respite care services

CHAPTER 64
INTERMEDIATE CARE FACILITIES FOR THE
INTELLECTUALLY DISABLED

64.1 Reserved
64.2(135C) Variances
64.3(135C) Application for license
64.4(135C) General requirements
64.5(135C) Notifications required by the department
64.6(135C) Veteran eligibility
64.7(135C) Licenses for distinct parts
64.8 to 64.16 Reserved
64.17(135C) Contracts
64.18(135C) Records
64.19 to 64.32 Reserved
64.33(135C) Allegations of dependent adult abuse
64.34(135C) 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
64.35 Reserved
64.36(135C) Involuntary discharge or transfer
64.37 to 64.59 Reserved
64.60(135C) Federal regulations adopted—conditions of participation
64.61(135C) Federal regulations adopted—rights
64.62(135C) Another business or activity in a facility
64.63(135C) Respite care services

CHAPTER 65
INTERMEDIATE CARE FACILITIES
FOR PERSONS WITH MENTAL ILLNESS (ICF/PMI)

65.1(135C) Definitions
65.2(135C) Application for license
65.3(135C) Licenses for distinct parts
65.4(135C) Variances
65.5(135C) General requirements
65.6(135C) Notification required by the department
65.7(135C) Administrator
65.8(135C) Administration
65.9(135C) Personnel
65.10(135C) General admission policies
65.11(135C) Evaluation services
65.12(135C) Individual program plan (IPP)
65.13(135C) Activity program
65.14(135C) Crisis intervention
65.15(135C) Restraint or seclusion
65.16(135C) Discharge or transfer
65.17(135C) Medication management
65.18(135C) Resident property and personal affairs
65.19(135C) Financial affairs
65.20(135C) Records
65.21(135C) Health and safety
65.22(135C) Nutrition
65.23(135C) Physical facilities and maintenance
65.24 Reserved
65.25(135C) Residents' rights in general
65.26(135C) Incompetent residents
65.27(135C) County care facilities
65.28(135C) Violations
65.29(135C) Another business or activity in a facility
65.30(135C) Respite care services

CHAPTER 66
BOARDING HOMES

66.1(83GA,SF484) Definitions
66.2(83GA,SF484) Registration of boarding homes
66.3(83GA,SF484) Occupancy reports
66.4(83GA,SF484) Complaints
66.5(83GA,SF484) Investigations
66.6(83GA,SF484) Penalties
66.7(83GA,SF484) Public and confidential information

CHAPTER 67
GENERAL PROVISIONS FOR ELDER GROUP HOMES, ASSISTED LIVING PROGRAMS,
AND ADULT DAY SERVICES

67.1(231B,231C,231D) Definitions
67.2(231B,231C,231D) Program policies and procedures, including those for incident reports
67.3(231B,231C,231D) Tenant rights
67.4(231B,231C,231D) Program notification to the department
67.5(231B,231C,231D) Medications

67.6(231B,231C,231D) Another business or activity located in a program
67.7(231B,231C,231D) Waiver of criteria for retention of a tenant in the program
67.8(231B,231C,231D) All other waiver requests
67.9(231B,231C,231D) Staffing
67.10(17A,231B,231C,231D) Monitoring
67.11(231B,231C,231D) Complaint and program-reported incident report investigation procedure
67.12 Reserved
67.13(17A,231B,231C,231D,85GA,HF2365) Exit interview, final report, plan of correction
67.14(17A,231B,231C,231D,85GA,HF2365) Response to final report
67.15(17A,231B,231C,231D) Denial, suspension or revocation of a certificate
67.16(17A,231B,231C,231D) Conditional certification
67.17(17A,231B,231C,231D) Civil penalties
67.18(17A,231B,231C,231D) Judicial review
67.19(135C,231B,231C,231D) Criminal, dependent adult abuse, and child abuse record checks
67.20(17A,231C,231D) Emergency removal of tenants
67.21(231C) Nursing assistant work credit
67.22(231B,231C,231D) Public or confidential information

CHAPTER 68
ELDER GROUP HOMES

68.1(231B) Definitions
68.2(231B) Program certification and posting requirements
68.3(231B) Certification—application process
68.4(231B) Certification—application content
68.5(231B) Initial certification process
68.6(231B) Expiration of program certification
68.7(231B) Recertification process
68.8(231B) Notification of recertification
68.9(231B) Listing of all certified programs
68.10(231B) Change of ownership—notification to the department
68.11(231B) Cessation of program operation
68.12(231B) Occupancy agreement
68.13(231B) Evaluation of tenant
68.14(231B) Criteria for admission and retention of tenants
68.15(231B) Involuntary transfer from the program
68.16(231B) Tenant documents
68.17(231B) Service plans
68.18(231B) Nurse review
68.19(231B) Staffing
68.20(231B) Managed risk policy and managed risk consensus agreements
68.21(231B) Transportation
68.22(231B) Identification of veteran's benefit eligibility
68.23(231B) Resident advocate committees
68.24(231B) Life safety—emergency policies and procedures and structural safety requirements
68.25(231B) Structural standards
68.26(231B) Landlord and tenant Act

CHAPTER 69
ASSISTED LIVING PROGRAMS

69.1(231C) Definitions
69.2(231C) Program certification
69.3(231C) Certification of a nonaccredited program—application process

69.4(231C) Nonaccredited program—application content
69.5(231C) Initial certification process for a nonaccredited program
69.6(231C) Expiration of the certification of a nonaccredited program
69.7(231C) Recertification process for a nonaccredited program
69.8(231C) Notification of recertification for a nonaccredited program
69.9(231C) Certification or recertification of an accredited program—application process
69.10(231C) Certification or recertification of an accredited program—application content
69.11(231C) Initial certification process for an accredited program
69.12(231C) Recertification process for an accredited program
69.13(231C) Listing of all certified programs
69.14(231C) Recognized accrediting entity
69.15(231C) Requirements for an accredited program
69.16(231C) Maintenance of program accreditation
69.17(231C) Change of ownership—notification to the department
69.18(231C) Plan reviews of a building for a new program
69.19(231C) Plan review prior to the remodeling of a building for a certified program
69.20(231C) Cessation of program operation
69.21(231C) Occupancy agreement
69.22(231C) Evaluation of tenant
69.23(231C) Criteria for admission and retention of tenants
69.24(231C) Involuntary transfer from the program
69.25(231C) Tenant documents
69.26(231C) Service plans
69.27(231C) Nurse review
69.28(231C) Food service
69.29(231C) Staffing
69.30(231C) Dementia-specific education for program personnel
69.31(231C) Managed risk policy and managed risk consensus agreements
69.32(231C) Life safety—emergency policies and procedures and structural safety requirements
69.33(231C) Transportation
69.34(231C) Activities
69.35(231C) Structural requirements
69.36(231C) Dwelling units in dementia-specific programs
69.37(231C) Landlord and tenant Act
69.38(83GA,SF203) Identification of veteran's benefit eligibility
69.39(231C) Respite care services

CHAPTER 70
ADULT DAY SERVICES

70.1(231D) Definitions
70.2(231D) Program certification
70.3(231D) Certification of a nonaccredited program—application process
70.4(231D) Nonaccredited program—application content
70.5(231D) Initial certification process for a nonaccredited program
70.6(231D) Expiration of the certification of a nonaccredited program
70.7(231D) Recertification process for a nonaccredited program
70.8(231D) Notification of recertification for a nonaccredited program
70.9(231D) Certification or recertification of an accredited program—application process
70.10(231D) Certification or recertification of an accredited program—application content
70.11(231D) Initial certification process for an accredited program
70.12(231D) Recertification process for an accredited program
70.13(231D) Listing of all certified programs

70.14(231D) Recognized accrediting entity
70.15(231D) Requirements for an accredited program
70.16(231D) Maintenance of program accreditation
70.17(231D) Change of ownership—notification to the department
70.18(231D) Plan reviews of a building for a new program
70.19(231D) Plan review prior to the remodeling of a building for a certified program
70.20(231D) Cessation of program operation
70.21(231D) Contractual agreement
70.22(231D) Evaluation of participant
70.23(231D) Criteria for admission and retention of participants
70.24(231D) Involuntary discharge from the program
70.25(231D) Participant documents
70.26(231D) Service plans
70.27(231D) Nurse review
70.28(231D) Food service
70.29(231D) Staffing
70.30(231D) Dementia-specific education for program personnel
70.31(231D) Managed risk policy and managed risk consensus agreements
70.32(231D) Life safety—emergency policies and procedures and structural safety requirements
70.33(231D) Transportation
70.34(231D) Activities
70.35(231D) Structural requirements
70.36(231D) Identification of veteran's benefit eligibility

CHAPTER 71
SUBACUTE MENTAL HEALTH CARE FACILITIES

71.1(135G) Purpose—subacute mental health services
71.2(135G) Definitions
71.3(135G) Application for licensure
71.4(135G) Licenses for distinct parts
71.5(135G) Variances
71.6(135G) Provisional license
71.7(135G) General requirements
71.8(135G) Required notifications to the department
71.9(135G) Reports of dependent adult abuse
71.10(135G) Administrator
71.11(135G) Administration
71.12(135G) Personnel
71.13(135G) Admission, transfer, and discharge
71.14(135G) Treatment plan
71.15(135G) Crisis intervention
71.16(135G) Seclusion and restraint
71.17(135G) Medication management
71.18(135G) Records
71.19(135G) Residents' rights in general
71.20(135G) Health and safety

CHAPTER 72
PUBLIC ASSISTANCE
FRONT END INVESTIGATIONS

72.1(10A) Definitions
72.2(10A) Referrals

72.3(10A) Investigation procedures
72.4(10A) Findings

CHAPTER 73
MEDICAID FRAUD CONTROL BUREAU

73.1(10A) Definitions
73.2(10A) Complaints
73.3(10A) Investigative procedures
73.4(10A) Audit of clinical and fiscal records by the department
73.5(10A) Who shall be reviewed, audited, or investigated
73.6(10A) Auditing and investigative procedures
73.7(10A) Actions based on audit or investigative findings
73.8(10A) Confidentiality
73.9(10A) Appeal by provider of care

CHAPTER 74
ECONOMIC ASSISTANCE FRAUD BUREAU

74.1(10A) Definitions
74.2(10A) Responsibilities
74.3(10A) Procedures
74.4(10A) Investigations
74.5(10A) Executive branch investigations

CHAPTER 75
DIVESTITURE UNIT

75.1(10A) Definitions
75.2(10A) Referral process
75.3(10A) Referral review
75.4(10A) Investigation
75.5(10A) Organizing information
75.6(10A) Computation of debt
75.7(10A) Issuing notices
75.8(10A) Conducting informal conferences
75.9(10A) Failure to timely request hearing
75.10(10A) District court hearing
75.11(10A) Filing and docketing of the order
75.12(10A,22) Confidentiality

CHAPTERS 76 to 89
Reserved

CHAPTER 90
PUBLIC ASSISTANCE DEBT RECOVERY UNIT

90.1(10A) Definitions
90.2(10A) Recovery process
90.3(10A) Records
90.4(10A) Review
90.5(10A) Debt repayment
90.6(10A) Further collection action
90.7(10A) Appeal rights
90.8(10A) Data processing systems matches
90.9(10A) Confidentiality

CHAPTERS 91 to 99
Reserved

GAMES OF SKILL, CHANCE, BINGO AND RAFFLES

CHAPTER 100
ADMINISTRATION

100.1(10A,99B) Definitions
100.2(99B) Licensing
100.3(99B) License requirements
100.4(99B) Participation
100.5(99B) Posted rules
100.6(99B) Prizes
100.7(10A,99B) Records
100.8(10A,99B) Inspections
100.9(99B) Reports
100.10(99B) Extension of time to file quarterly report
100.11(10A,422) State and local option sales tax
100.12(10A,17A,99B) Appeal rights
100.13(99B) Penalties
100.14 to 100.29 Reserved

QUALIFIED ORGANIZATION

100.30(99B) License requirements
100.31 Reserved
100.32(99B) Raffles
100.33(99B) Expenses
100.34(99B) Nature and dedication of net receipts
100.35(99B) Extension of time to dedicate net receipts
100.36(10A,22) Confidentiality
100.37 to 100.49 Reserved

RAFFLES CONDUCTED AT A FAIR

100.50(99B) Raffles conducted at a fair
100.51(99B) Raffle prizes at a fair
100.52(99B) Exceptions for an annual raffle
100.53 to 100.79 Reserved

ANNUAL GAME NIGHT
BINGO MANUFACTURERS AND DISTRIBUTORS

100.80(99B) Bingo manufacturers and distributors
100.81(99B) Bingo manufacturer and distributor licenses
100.82(99B) Bingo supplies and equipment

CHAPTER 101
AMUSEMENT CONCESSIONS

101.1(99B) License requirements
101.2(99B) Prizes
101.3(99B) Conducting games
101.4(99B) Posted rules

CHAPTER 102
Reserved

CHAPTER 103
BINGO

103.1(10A,99B) Definitions
103.2(10A,99B) License
103.3(99B) Bingo occasion
103.4(99B) Game of bingo
103.5(99B) State and house rules
103.6(99B) Prizes
103.7(10A,99B) Workers
103.8(99B) Expenses
103.9(99B) Location
103.10 Reserved
103.11(10A,725) Advertising
103.12(10A,99B) Equipment
103.13(99B) Records
103.14(10A,99B) Bingo checking account
103.15(10A,99B) Bingo savings account and bingo change fund
103.16(10A,99B) Reports
103.17(10A,99B) Inspections and audits
103.18(10A,99B) Penalties
103.19(99B) Electronic bingo

CHAPTER 104
GENERAL PROVISIONS FOR ALL AMUSEMENT DEVICES

104.1(10A,99B) Definitions
104.2(99B) Device restrictions
104.3(99B) Prohibited games/devices
104.4(99B) Prizes
104.5(99B) Registration
104.6(99B) Violations

CHAPTER 105
REGISTERED AMUSEMENT DEVICES

105.1(10A,99B) Definitions
105.2(99B) Registered amusement device restrictions
105.3(99B) Prohibited registered amusement devices
105.4(99B) Prizes
105.5(99B) Registration by a manufacturer, manufacturer's representative, distributor, or an owner that operates for profit
105.6(99B) Registration of registered amusement devices
105.7(99B) Violations
105.8(10A,99B) Appeal rights
105.9(10A,99B,82GA,SF510) Procedure for denial, revocation, or suspension of a registration
105.10(99B) Annual verification of device location
105.11(99B) Criteria for approval or denial of a registration
105.12(10A,99B) Suspension or revocation of a registration

CHAPTER 106
CARD GAME TOURNAMENTS BY VETERANS ORGANIZATIONS

106.1(10A,99B) Definitions
106.2(99B) Licensing
106.3(99B) Card game tournament
106.4(99B) Required postings

106.5(99B)	Prizes and cost to participate
106.6(99B)	Restrictions
106.7(99B)	Qualified expenses limitation
106.8(99B)	Records
106.9(99B)	State and local option sales tax
106.10(99B)	Inspections
106.11(99B)	Quarterly reports
106.12(99B)	Penalties
106.13(99B)	Revocation, suspension, or denial of license

INSPECTIONS DIVISION

CHAPTER 30
FOOD AND CONSUMER SAFETY

481—30.1(10A,137C,137D,137F) Food and consumer safety bureau. The food and consumer safety bureau inspects food establishments and food processing plants including food storage facilities (warehouses), home bakeries, food and beverage vending machines, and hotels and motels. The food and consumer safety bureau is also responsible for social and charitable gambling and amusement devices. Separate chapters have been established for the administration of targeted small business certification (481—Chapter 25), social and charitable gambling (481—Chapters 100 to 103, 106, and 107), and amusement devices (481—Chapters 104 and 105).

This rule is intended to implement Iowa Code sections 10A.104 and 22.11 and Iowa Code chapters 137C, 137D and 137F.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14; **ARC 3187C**, IAB 7/5/17, effective 8/9/17]

481—30.2(10A,137C,137D,137F) Definitions. If both the 2009 Food and Drug Administration Food Code with Supplement and rule 481—30.2(10A,137C,137D,137F) define a term, the definition in rule 481—30.2(10A,137C,137D,137F) shall apply.

"Baked goods" means breads, cakes, doughnuts, pastries, buns, rolls, cookies, biscuits and pies (except meat pies).

"Bed and breakfast home" means a private residence which provides lodging and meals for guests, in which the host or hostess resides, and in which no more than four guest families are lodged at the same time. The facility may advertise as a bed and breakfast home but not as a hotel, motel or restaurant. The facility is exempt from licensing and inspection as a hotel or as a food establishment. A bed and breakfast home may serve food only to overnight guests, unless a food establishment license is secured.

"Bed and breakfast inn" means a hotel which has nine or fewer guest rooms.

"Catering" means the preparation of food for distribution to an individual, business or organization for exclusive service to the individual's, business's or organization's nonpaying guests, employees or members.

"Commissary" means a food establishment used for preparing, fabricating, packaging and storage of food or food products for distribution and sale through the food establishment's own outlets.

"Contractor" means a municipal corporation, county or other political subdivision that contracts with the department to license and inspect under Iowa Code chapter 137C, 137D or 137F. A list of contractors is maintained on the department's Web site.

"Criminal offense" means a public offense, as defined in Iowa Code section 701.2, that is prohibited by statute and is punishable by fine or imprisonment.

"Critical violation" means a foodborne illness risk factor and public health intervention and the violations defined as such by the Food Code adopted in rule 481—31.1(137F) and pursuant to Iowa Code section 137F.2.

"Department" means the department of inspections and appeals.

"Farmers market" means a marketplace which operates seasonally, principally as a common market for Iowa-produced farm products on a retail basis for consumption elsewhere.

"Farmers market potentially hazardous food license" means a license for a temporary food establishment that sells potentially hazardous foods at farmers markets. A separate annual farmers market potentially hazardous food license is required for each county in which the licensee sells potentially hazardous foods at farmers markets. The license is only applicable at farmers markets and is not required in order to sell wholesome, fresh shell eggs to consumer customers.

"Food establishment" means an operation that stores, prepares, packages, serves, vends or otherwise provides food for human consumption and includes a food service operation in a salvage or distressed food operation, nutrition program operated pursuant to Title III-C of the Older Americans Act, school, summer camp, residential service substance abuse treatment facility, halfway house substance abuse treatment facility, correctional facility operated by the department of corrections, the

state training school and the Iowa juvenile home. Assisted living programs and adult day services are included in the definition of food establishment to the extent required by 481—subrules 69.28(6) and 70.28(6). "Food establishment" does not include the following:

1. A food processing plant.
2. An establishment that offers only prepackaged foods that are not potentially hazardous.
3. A produce stand or facility which sells only whole, uncut fresh fruits and vegetables.
4. Premises which are a home bakery pursuant to Iowa Code chapter 137D.
5. Premises which operate as a farmers market.
6. Premises of a residence in which food that is not potentially hazardous is sold for consumption off the premises to a consumer customer, if the food is labeled to identify the name and address of the person preparing the food and the common name of the food. This exception does not apply to resale goods. This exception applies only to sales made from the residence in person and does not include mail order or Internet sales.
7. A kitchen in a private home where food is prepared or stored for family consumption or in a bed and breakfast home.
8. A private home or private party where a personal chef or hired cook is providing food preparation services to a client and the client's nonpaying guests.
9. A private home that receives catered or home-delivered food.
10. Child day care facilities and other food establishments located in hospitals or health care facilities that serve only patients and staff and are subject to inspection by other state agencies or divisions of the department.
11. Supply vehicles or vending machine locations.
12. Establishments that are exclusively engaged in the processing of meat and poultry and are licensed pursuant to Iowa Code section 189A.3.
13. The following premises, provided they are exclusively engaged in the sale of alcoholic beverages in a prepackaged form:

- Premises covered by a current Class "A" beer permit, including a Class "A" native beer permit as provided in Iowa Code chapter 123;
- Premises covered by a current Class "A" wine permit, including a Class "A" native wine permit as provided in Iowa Code chapter 123; and
- Premises of a manufacturer of distilled spirits under Iowa Code chapter 123.

14. Premises or operations that are exclusively engaged in the processing of milk and milk products, are regulated by Iowa Code section 192.107, and have a milk or milk products permit issued by the department of agriculture and land stewardship.
15. Premises or operations that are exclusively engaged in the production of shell eggs, are regulated by Iowa Code section 196.3, and have an egg handler's license.
16. The premises of a residence in which honey is stored; prepared; packaged, including by placement in a container; or labeled or from which honey is distributed.
17. Premises regularly used by a nonprofit organization which engages in the serving of food on the premises as long as the nonprofit organization does not exceed the following restrictions:

- The nonprofit organization serves food no more than one day per calendar week and not on two or more consecutive days;
- Twice per year, the nonprofit organization may serve food to the public for up to three consecutive days; and
- The nonprofit organization may use the premises of another nonprofit organization not more than twice per year for one day to serve food.

"Food processing plant" means a commercial operation that manufactures, packages, labels or stores food for human consumption and does not provide food directly to a consumer. "Food processing plant" does not include any of the following:

1. The following premises, provided they are exclusively engaged in the sale of alcoholic beverages in a prepackaged form:

- Premises covered by a current Class "A" beer permit, including a Class "A" native beer permit as provided in Iowa Code chapter 123;
- Premises covered by a current Class "A" wine permit, including a Class "A" native wine permit as provided in Iowa Code chapter 123; and
- Premises of a manufacturer of distilled spirits under Iowa Code chapter 123.

2. The premises of a residence in which honey is stored; prepared; packaged, including by placement in a container; or labeled or from which honey is distributed.

3. Premises or operations that are exclusively engaged in the processing of meat and poultry and are licensed pursuant to Iowa Code section 189A.3.

4. Premises or operations that are exclusively engaged in the processing of milk or milk products, are regulated by Iowa Code section 192.107, and have a milk or milk products permit issued by the department of agriculture and land stewardship.

5. Premises or operations that are exclusively engaged in the production of shell eggs, are regulated by Iowa Code section 196.3, and have an egg handler's license.

"Food service establishment" means a food establishment where food is prepared or served for individual portion service intended for consumption on the premises or is subject to Iowa sales tax as provided in Iowa Code section 423.3.

"Home bakery" means a business on the premises of a residence that is operating as a home-based bakery where baked goods are prepared for consumption elsewhere. Annual gross sales of these products cannot exceed $35,000. "Home bakery" does not include:

1. A food establishment;
2. A food processing plant;
3. A residence where food is prepared to be used or sold by churches, fraternal societies, or charitable, civic or nonprofit organizations;
4. A residence that prepares or distributes honey;
5. A residence that distributes shell eggs;
6. A residence that prepares nonhazardous foods for sale at a farmers market; or
7. A residence that prepares nonhazardous baked goods sold directly from the residence. This exception does not apply to resale goods. This exception applies only to sales made from the residence in person and does not include mail order or Internet sales.

"Hotel" means any building equipped, used or advertised to the public as a place where sleeping accommodations are rented to temporary or transient guests.

"License holder" means an individual, corporation, partnership, governmental unit, association or any other entity to whom a license was issued under Iowa Code chapter 137C, 137D or 137F.

"Mobile food unit" means a food establishment that is self-contained, with the exception of grills and smokers, and readily movable, which either operates up to three consecutive days at one location or returns to a home base of operation at the end of each day.

"Personal chef" or *"hired cook"* means a person who provides food preparation services in a private home or at a private party for a client and the client's nonpaying guests. "Personal chef" or "hired cook" does not include a person who provides the ingredients intended to be used in food preparation.

"Pushcart" means a non-self-propelled vehicle food establishment limited to serving nonpotentially hazardous foods or commissary-wrapped foods maintained at proper temperatures or precooked foods that require limited assembly, such as frankfurters.

"Retail food establishment" means a food establishment that sells to consumer customers food or food products intended for preparation or consumption off the premises.

"Revoke" means to void or annul by recalling or withdrawing a license issued under Iowa Code chapter 137C, 137D or 137F. The entire application process, including the payment of applicable license fees, must be repeated to regain a valid license following a revocation.

"Suspend" means to render a license issued under Iowa Code chapter 137C, 137D, or 137F invalid for a period of time, with the intent of resuming the validity of a license at the end of that period.

"Temporary food establishment" means a food establishment that operates for a period of no more than 14 consecutive days in conjunction with a single event or celebration. An "event or celebration"

is a significant occurrence or happening sponsored by a civic, business, educational, government, community, or veterans' organization and may include athletic contests. For example, an event does not include a single store's grand opening or sale.

"Transient guest" means an overnight lodging guest who does not intend to stay for any permanent length of time. Any guest who rents a room for more than 31 consecutive days is not classified as a transient guest.

"Unattended food establishment" means an operation that provides packaged foods or whole fruit using an automated payment system and has controlled entry not accessible by the general public. "Controlled entry," for the purposes of the definition of "unattended food establishment," means selective restriction or limitation of access to a place or location.

"Vending machine" means a food establishment which is a self-service device that, upon insertion of a coin, paper currency, token, card or key, dispenses unit servings of food in bulk or in packages without the necessity of replenishing the device between each vending operation. Vending machines that dispense only prepackaged, nonpotentially hazardous foods, panned candies, gumballs or nuts are exempt from licensing but may be inspected by the department upon receipt of a written complaint. "Panned candies" are those with a fine, hard coating on the outside and a soft candy filling on the inside. Panned candies are easily dispensed by a gumball-type machine.

This rule is intended to implement Iowa Code sections 10A.104, 137C.8, and 137D.2 and chapter 137F.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14; **ARC 3187C**, IAB 7/5/17, effective 8/9/17]

481—30.3(137C,137D,137F) Licensing and postings. A license to operate any food establishment or food processing plant defined in rule 481—30.2(10A,137C,137D,137F) must be granted by the department of inspections and appeals. Application for a license is made on a form furnished by the department which contains the names of the business, owner, and manager; locations of buildings; and other data relative to the license requested. Applications are available from the Department of Inspections and Appeals, Food and Consumer Safety Bureau, Lucas State Office Building, Des Moines, Iowa 50319-0083, or from contractors. An application for licensure shall be submitted 30 days in advance of the opening of the food establishment or food processing plant. Temporary food establishment license applications shall be submitted a minimum of 3 business days prior to opening.

30.3(1) *Transferability.* A license is not transferable to a new owner or location. Any change in business ownership or business location requires a new license. Vending machines, mobile food units and pushcarts may be moved without obtaining a new license. A farmers market potentially hazardous food license may be used in the same county at different individual locations without obtaining a new license. However, if the different individual locations are operated simultaneously, a separate license is required for each location. Nutrition sites for the elderly licensed under Iowa Code chapter 137F may change locations in the same city without obtaining a new license.

30.3(2) *Refunds.* License fees are refundable only if the license is surrendered to the department prior to the effective date of the license and only as follows:

a. License fees of $67.50 or less are an application processing fee and are not refundable.

b. If an on-site visit has not occurred, license fees of more than $67.50 will be refunded less the $67.50.

c. If an on-site visit has occurred, the entire license fee is nonrefundable.

30.3(3) *License expiration.* A license is renewable and expires after one year, with the exception of a temporary food establishment license, which is event- and location-specific and is valid for a period not to exceed 14 consecutive days.

30.3(4) *Posting of inspection reports, licenses, and registration tags.* A valid license and the most recent inspection report, along with any current complaint or reinspection reports, shall be posted no higher than eye level where the public can see them. The report shall not be posted in such a manner that the public cannot reasonably read the report. For example, the posting of a report behind a service area where the report can be seen but not easily read is not allowed. Vending machines shall bear a tag to affirm the license. For the purpose of this subrule, only founded complaint reports shall be considered

complaints. Founded complaints shall be posted until either the mail-in recheck form has been submitted to the regulatory authority or a recheck inspection has been conducted to verify that the violations have been corrected.

30.3(5) *Documentation of gross sales.* The regulatory authority shall require from a license holder documentation of the annual gross sales of food and drink sold by a licensed food establishment or a licensed food processing plant unless the establishment is paying the highest license fee required by rule 481—30.4(137C,137D,137F). The documentation submitted by the license holder will be kept confidential and will be used to verify that the license holder is paying the appropriate license fee based on annual gross sales of food and drink. For food processing plants that are food storage facilities and food establishments whose sales are included in a single rate with lodging or other services, the value of the food handled should be used. Documentation shall include at least one of the following:

a. A copy of the firm's business tax return;

b. Quarterly sales tax data;

c. A letter from an independent tax preparer;

d. Other appropriate records.

30.3(6) *License eligibility for renewal limited to 60 days after expiration.* A delinquent license shall only be renewed if application for renewal is made within 60 days of expiration of the license. If a delinquent license is not renewed within 60 days, an establishment must apply for a new license and meet all the requirements for licensure. Establishments that have not renewed the license within 60 days of the expiration of the license shall be closed by the department or a contractor. The establishment shall not be reopened until a new license application has been submitted and approved.

This rule is intended to implement Iowa Code sections 10A.104, 137C.8, and 137D.2 and chapter 137F.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14]

481—30.4(137C,137D,137F) License fees. The license fee is the same for an initial license and a renewal license. License applications are available from the Department of Inspections and Appeals, Food and Consumer Safety Bureau, Lucas State Office Building, Des Moines, Iowa 50319-0083, or from a contractor. License fees are set by the Iowa Code sections listed below and are charged as follows:

30.4(1) *Retail food establishments.* License fees for retail food establishments are based on annual gross sales of food or food products to consumer customers and intended for preparation or consumption off the premises (Iowa Code section 137F.6) as follows:

a. For annual gross sales of less than $10,000—$40.50.

b. For annual gross sales of $10,000 to $250,000—$101.25.

c. For annual gross sales of $250,000 to $500,000—$155.25.

d. For annual gross sales of $500,000 to $750,000—$202.50.

e. For annual gross sales of $750,000 or more—$303.75.

30.4(2) *Food service establishments.* License fees for food service establishments are based on annual gross sales of food and drink for individual portion service intended for consumption on the premises (Iowa Code section 137F.6) or subject to Iowa sales tax as provided in Iowa Code section 423.3 as follows:

a. For annual gross sales of less than $50,000—$67.50.

b. For annual gross sales of $50,000 to $100,000—$114.50.

c. For annual gross sales of $100,000 to $250,000—$236.25.

d. For annual gross sales of $250,000 to $500,000—$275.00.

e. For annual gross sales of $500,000 or more—$303.75.

30.4(3) *Vending machines.* License fees for food and beverage vending machines are $20 for the first machine and $5 for each additional machine (Iowa Code section 137F.6).

30.4(4) *Home bakery.* The license fee for a home bakery is $33.75 (Iowa Code section 137D.2(1)).

30.4(5) *Hotels.* License fees for hotels are based on the number of rooms provided to transient guests (Iowa Code section 137C.9) as follows:

a. For 1 to 15 guest rooms—$27.00.

b. For 16 to 30 guest rooms—$40.50.
c. For 31 to 75 guest rooms—$54.00.
d. For 76 to 149 guest rooms—$57.50.
e. For 150 or more guest rooms—$101.25.

30.4(6) *Mobile food units or pushcarts.* The license fee for a mobile food unit or a pushcart is $27 (Iowa Code section 137F.6).

30.4(7) *Temporary food service establishments.* The fee for a temporary food service establishment license issued for up to 14 consecutive days in conjunction with a single event or celebration is $33.50 (Iowa Code section 137F.6).

30.4(8) *Food processing plants including food storage facilities (warehouses).* For food processing plants, the annual license fee is based on the annual gross sales of food and food products handled at that plant or food storage facility (warehouse) (Iowa Code section 137F.6) as follows:

a. Annual gross sales of less than $50,000—$67.50.
b. Annual gross sales of $50,000 to $250,000—$135.00.
c. Annual gross sales of $250,000 to $500,000—$202.50.
d. Annual gross sales of $500,000 or more—$337.50.

30.4(9) *Farmers market.* A person selling potentially hazardous food at a farmers market must pay an annual license fee of $100 for each county of operation. Persons who operate simultaneously at more than one location within a county are required to have a separate license for each location.

30.4(10) *Discount.* If an establishment renews its license as a retail food establishment or food service establishment and has had a person in charge for the entire previous 12-month period who holds an active certified food protection manager certificate from a program approved by the Conference on Food Protection and the establishment has not been issued a critical violation during the previous 12-month period, the establishment's license fee for the current renewal period shall be reduced by $50 but no more than the establishment's total license fee(s).

30.4(11) *Voluntary inspection fee.* The department shall charge a voluntary inspection fee of $100 when a premises that is not a food establishment requests a voluntary inspection.

This rule is intended to implement Iowa Code sections 137C.9, 137D.2(1), and 137F.6.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14; **ARC 3187C**, IAB 7/5/17, effective 8/9/17]

481—30.5(137F) Penalty and delinquent fees.

30.5(1) *Late penalty.* Food establishment licenses and food processing plant licenses that are renewed by the licensee after the license expiration date shall be subject to a penalty of 10 percent of the license fee per month. A license shall be renewed only if the license holder has provided documentation pursuant to subrule 30.3(5).

30.5(2) *Penalty for opening or operating without a license.* A person who opens or operates a food establishment or food processing plant without a license is subject to a penalty of up to twice the amount of the annual license fee.

30.5(3) *Civil penalty for violations.* A person who violates Iowa Code chapter 137F or these rules shall be subject to a civil penalty of $100 for each violation. Prior to assessment of the penalty, the license holder shall have an opportunity for a hearing using the process outlined in rule 481—30.11(10A,137C,137D,137F).

This rule is intended to implement Iowa Code sections 137F.4, 137F.9 and 137F.17.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14]

481—30.6(137C,137D,137F) Returned checks. If a check intended to pay for any license provided for under Iowa Code chapter 137C, 137D, or 137F is not honored for payment by the bank on which it is drafted, the department will attempt to redeem the check. The department will notify the applicant of the need to provide sufficient payment. An additional fee of $25 shall be assessed for each dishonored check. If the department does not receive cash to replace the check, the establishment will be operating

without a valid license. Furthermore, any late penalties assessed pursuant to rule 481—30.5(137F) will accrue and must be paid.

This rule is intended to implement Iowa Code sections 137C.9, 137D.2(1), and 137F.6.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14]

481—30.7(137F) Double licenses.

30.7(1) Any establishment which holds a food service establishment license and has gross sales over $20,000 annually in packaged food items intended for consumption off the premises shall also be required to obtain a retail food establishment license. The license holder shall keep a record of these food sales and make it available to the department upon request.

30.7(2) A retail food establishment and a food service establishment which occupy the same premises must be licensed separately, and the applicable fees must be paid for each. The license fee for each is based on only the annual gross sales of food and drink covered under the scope of that particular type of license.

30.7(3) A food establishment that is licensed both with a food service establishment license and a retail food establishment license shall pay 75 percent of the license fees required in subrules 30.4(1) and 30.4(2).

30.7(4) Licensed retail food establishments serving only coffee, soft drinks, popcorn, prepackaged sandwiches or other food items manufactured and packaged by a licensed establishment need only obtain a retail food establishment license.

30.7(5) A temporary food establishment license is not required when the temporary food establishment is owned and operated on the premises of a licensed food establishment.

30.7(6) The dominant form of business in annual gross sales shall determine the type of license for establishments which engage in operations covered under the definitions of both a food establishment and a food processing plant. Sale of products at wholesale to outlets not owned by a commissary owner requires a food processing plant license. Food establishments that process low-acid food in hermetically sealed containers or process acidified foods are required to have a food processing plant license. Regardless of the license, food processing facilities shall be inspected pursuant to food processing inspection standards and food establishments shall be inspected pursuant to the Food Code.

30.7(7) A licensed mobile food unit that operates as a licensed mobile food unit at a farmers market is not required to obtain a separate farmers market potentially hazardous food license.

This rule is intended to implement Iowa Code sections 10A.104 and 137F.6.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14]

481—30.8(137C,137D,137F) Inspection frequency.

30.8(1) *Food establishments.* Food establishments shall be inspected based upon risk assessment and shall have routine inspections at least once every 24 months and no more than once every 3 months.

30.8(2) *Food processing plants.* Food processing plants that process foods shall be inspected based upon risk assessment and shall have routine inspections at least once every 24 months and no more than once every 6 months.

30.8(3) *Food processing plants that store foods.* Food processing plants that store foods shall be inspected based upon risk assessment and shall be inspected at least once every 36 months.

30.8(4) *Hotels.* Hotels shall be inspected at least once biennially.

30.8(5) *Home bakeries and vending machines.* Home bakeries and vending machines shall be inspected at least once every 24 months.

30.8(6) *Farmers market potentially hazardous food.* Farmers market potentially hazardous food licensees shall be inspected at least once annually.

This rule is intended to implement Iowa Code sections 137C.11, 137D.2, and 137F.10.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14; **ARC 3187C**, IAB 7/5/17, effective 8/9/17]

481—30.9(22) Examination of records.

30.9(1) *Public information.* Generally, information collected by the food and consumer safety bureau and contractors is considered public information. Records are stored in computer files and are

not matched with any other data system. Information is available for public review and will be provided when requested from the office of the director. Inspection reports are available for public viewing at http://www.food.dia.iowa.gov.

30.9(2) *Confidential records.* The following are examples of confidential records:

a. Trade secrets and proprietary information including items such as formulations, processes, policies and procedures, and customer lists;

b. Health information related to foodborne illness complaints and outbreaks; and

c. Other state or federal agencies' records.

For records of other federal or state agencies, the department shall refer the requester of such information to the appropriate agency.

This rule is intended to implement Iowa Code chapters 137C, 137D, 137F and 22.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14]

481—30.10(17A,137C,137D,137F) Denial, suspension, or revocation of a license to operate. Notice of denial, suspension or revocation of a license will be provided by the department and shall be effective 30 days after mailing or personal service of the notice.

30.10(1) *Immediate suspension of license.* To the extent not inconsistent with Iowa Code chapters 17A, 137C, 137D, and 137F and rules adopted pursuant to those chapters, chapter 8 of the Food Code shall be adopted for food establishments and home bakeries. The department or contractor may immediately suspend a license in cases of an imminent health hazard. The procedures of Iowa Code section 17A.18A and Food Code chapter 8 shall be followed in cases of an imminent health hazard. The appeal process in rule 481—30.11(10A,137C,137D,137F) is available following an immediate suspension. The department may immediately suspend the license of a food processing plant or hotel if an imminent health hazard finding is made and the procedures of Iowa Code section 17A.18A are followed.

30.10(2) *Criminal offense—conviction of license holder.*

a. The department may revoke the license of a license holder who:

(1) Conducts an activity constituting a criminal offense in the licensed food establishment; and

(2) Is convicted of a felony as a result.

b. The department may suspend or revoke the license of a license holder who:

(1) Conducts an activity constituting a criminal offense in the licensed food establishment; and

(2) Is convicted of a serious misdemeanor or aggravated misdemeanor as a result.

c. A certified copy of the final order or judgment of conviction or plea of guilty shall be conclusive evidence of the conviction of the license holder.

d. The department's decision to revoke or suspend a license may be contested by the adversely affected party pursuant to the provisions of rule 481—30.11(10A,137C,137D,137F).

This rule is intended to implement Iowa Code chapters 17A, 137C, 137D and 137F.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14; **ARC 3187C**, IAB 7/5/17, effective 8/9/17]

481—30.11(10A,137C,137D,137F) Formal hearing. All decisions of the food and consumer safety bureau may be contested by an adversely affected party. A request for a hearing must be made in writing to the Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319, within 30 days of the mailing or service of a decision. Appeals and hearings are controlled by 481—Chapter 10, "Contested Case Hearings."

For contractors, license holders shall have the opportunity for a hearing before the local board of health. If the hearing is conducted before the local board of health, the license holder may appeal to the department and shall follow the process for review in rule 481—10.25(10A,17A).

This rule is intended to implement Iowa Code section 10A.104 and Iowa Code chapters 137C, 137D, and 137F.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14]

481—30.12(137F) Primary servicing laboratory. The primary servicing laboratory for the food and consumer safety bureau is the State Hygienic Laboratory at the University of Iowa created under Iowa

Code section 263.7. If the laboratory is unable to perform laboratory services, the laboratory will assist in finding another laboratory with a preference toward laboratories that are in the FERN (Food Emergency Response Network) and have achieved ISO 17025 accreditation.

This rule is intended to implement Iowa Code sections 10A.104 and 22.11 and Iowa Code chapters 137C, 137D, and 137F.

[**ARC 1190C**, IAB 11/27/13, effective 1/1/14]

[Filed 8/6/87, Notice 7/1/87—published 8/26/87, effective 9/30/87]
[Filed 1/8/88, Notice 11/18/87—published 1/27/88, effective 3/2/88]
[Filed 3/3/88, Notice 1/27/88—published 3/23/88, effective 4/27/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 8/5/88, Notice 6/29/88—published 8/24/88, effective 9/28/88]
[Filed 2/3/89, Notice 12/14/88—published 2/22/89, effective 3/29/89]
[Filed 2/17/89, Notice 1/11/89—published 3/8/89, effective 4/12/89]
[Filed 4/28/89, Notice 3/22/89—published 5/17/89, effective 6/21/89]
[Filed 7/20/89, Notice 5/31/89—published 8/9/89, effective 9/13/89]
[Filed 10/27/89, Notice 8/23/89—published 11/15/89, effective 12/20/89]
[Filed 5/25/90, Notice 4/4/90—published 6/13/90, effective 7/18/90]
[Filed 12/20/90, Notice 10/31/90—published 1/9/91, effective 2/13/91]
[Filed 4/12/91, Notice 3/6/91—published 5/1/91, effective 6/5/91]
[Filed 9/23/91, Notice 8/7/91—published 10/16/91, effective 11/20/91]
[Filed 9/10/92, Notice 7/22/92—published 9/30/92, effective 11/4/92]
[Filed 9/22/93, Notices 4/14/93, 7/21/93—published 10/13/93, effective 11/17/93]
[Filed 11/3/94, Notice 9/14/94—published 11/23/94, effective 12/28/94]
[Filed 9/7/95, Notice 7/5/95—published 9/27/95, effective 11/1/95]
[Filed 10/16/97, Notice 8/27/97—published 11/5/97, effective 12/10/97]
[Filed 1/21/99, Notice 12/16/98—published 2/10/99, effective 3/17/99]
[Filed 9/1/99, Notice 7/28/99—published 9/22/99, effective 10/27/99]
[Filed 7/5/00, Notice 5/31/00—published 7/26/00, effective 8/30/00]
[Filed emergency 7/10/01—published 8/8/01, effective 7/10/01]
[Filed 9/26/01, Notice 8/8/01—published 10/17/01, effective 11/21/01]
[Filed emergency 6/7/02—published 6/26/02, effective 6/7/02]
[Filed 3/21/08, Notice 12/5/07—published 4/9/08, effective 7/1/08]
[Editorial correction to 30.4(11) published 6/4/08, effective 7/1/08]
[Filed ARC 1190C (Notice ARC 1026C, IAB 9/18/13), IAB 11/27/13, effective 1/1/14]
[Filed ARC 3187C (Notice ARC 3052C, IAB 5/10/17), IAB 7/5/17, effective 8/9/17]

CHAPTER 31
FOOD ESTABLISHMENT AND FOOD PROCESSING PLANT INSPECTIONS

[Prior to 8/26/87, see Inspections and Appeals Department[481]—Chs 21 and 22]

481—31.1(137F) Inspection standards for food establishments.[2] The department adopts, with the following exceptions, the 2013 Food Code with Supplement of the Food and Drug Administration as the state's "food code," which is the inspection standard for food establishments other than food processing plants.

31.1(1) *Unattended food establishments—assignment of responsibility.* For the purposes of section 2-101.11 of the 2013 Food Code with Supplement, unattended food establishments are not required to have a designated person in charge present during all hours of operation provided that the permit holder ensures the following requirements are met.

a. Unattended food establishment location. The unattended food establishment shall be located in the interior of a building that is not accessible by the general public. Access to the unattended food establishment shall be limited to a defined population (e.g., employees or occupants of the building where the establishment is located).

b. Nature and source of food and beverages offered for sale.

(1) Only commercially packaged foods properly labeled for individual retail sale, pursuant to Food Code section 3-201.11(C), shall be offered.

(2) No unpackaged food is permitted except as provided by section 3-302.11(B)(1) of the Food Code.

(3) Food preparation by consumers is limited to heating/reheating food in a microwave oven.

(4) No dispensing of bulk food is permitted.

c. Refrigerated display equipment. An unattended food establishment shall be equipped with refrigeration or freezer units that have the following features:

(1) Self-closing doors that allow food to be viewed without opening the door to the refrigerated cooler or freezer; and

(2) An automatic self-locking mechanism that prevents the consumer from accessing the food upon the occurrence of any condition that results in the failure of the refrigeration unit to maintain the internal product temperature specified under section 3-501.16(A)(2) or of the freezer unit to maintain the product as frozen.

d. Food service equipment limitations.

(1) Beverages are dispensed by individual serving only. Beverage dispensers connected to the building water supply must be properly equipped with backflow prevention pursuant to section 5-203.14 of the Food Code.

(2) Food-contact surfaces.

1. Multiuse food-contact surfaces shall be cleaned on a frequency consistent with the service pursuant to section 4-202.11 of the Food Code or can be and are easily removed and replaced with cleaned surfaces.

2. No multiuse food-contact surfaces intended for use with time/temperature control for safety foods are permitted.

e. Security.

(1) An unattended food establishment shall provide continuous video surveillance of areas where consumers view, select, handle and purchase products. The continuous video surveillance shall provide sufficient resolution to identify situations that may compromise food safety or food defense.

1. Video surveillance recordings shall be maintained and, upon request by a representative of a regulatory agency, made available for inspection within 24 hours of the request.

2. Video surveillance recordings shall be held by the establishment for a minimum of 14 days after the date of the surveillance.

(2) The permit holder shall take reasonable steps necessary to discourage individuals from returning food, beverages, or both that have not been selected for purchase.

f. *Routine maintenance at an unattended food establishment.*

(1) The permit holder shall service the unattended food establishment at least weekly. Service may include, but is not limited to, the following:

1. Checking food supplies and equipment for signs of product damage, tampering, or both.
2. Verifying that refrigeration equipment is operating properly, including the temperature display and self-locking mechanism.
3. Rotating foods to better ensure first in/first out of food items.
4. Cleaning food service equipment and food display areas.
5. Stocking food and disposable single-use and single-service supplies.
6. Checking inventory for recalled foods.

(2) The permit holder shall ensure that:

1. Food is from an approved source.
2. Packaged food is provided in tamper-evident packaging.
3. Food is protected from potential sources of cross contamination.
4. Food is maintained at safe temperatures during transport and display.

g. *Unattended food establishment oversight.* Each unattended food establishment shall have a sign readily visible at the automated payment station stating:

(1) The name and mailing address of the business entity responsible for the establishment and to whom complaints and comments should be addressed.

(2) The telephone number, e-mail address or Web information for the responsible business entity, when applicable.

h. *Designation of responsibilities.* The permit holder bears all responsibilities for the operation of the food establishment. When the permit holder is not the owner or operator of the building where the food establishment is located, a mutual agreement that outlines the responsibilities for cleaning and maintenance of all surfaces and equipment and for provision of supportive facilities/services, such as janitorial services and restroom facilities, pest control and removal of solid waste, may be approved by the regulatory agency. This agreement should also outline actions that must be taken by both parties to maintain the establishment in compliance with all requirements including responding to imminent health hazards.

i. *Inspections—on-site person in charge.* When requested by the regulatory authority for the purposes of conducting an inspection, the permit holder shall provide an on-site person in charge within a reasonable time frame not to exceed four hours.

31.1(2) *Certified food protection manager required—exceptions and time frames for employment.*

a. For purposes of section 2-102.12 of the 2013 Food Code with Supplement, the following food establishments are not required to employ an individual who is a certified food protection manager:

(1) Food establishments that sell only prepackaged food.

(2) Temporary or farmers market food establishments.

(3) Food establishments at which food is not prepared, where customers may purchase beverages, and where the service of food is limited to the service of ice, beverages, prepackaged snack foods, popcorn, or peanuts and to the reheating of commercially prepared foods for immediate service that do not require assembly, such as frozen pizza or prepackaged sandwiches.

(4) Food establishments at which food is not prepared, where customers may purchase only commercially prepared nonpotentially hazardous foods that are dispensed either unpackaged or packaged and are intended for off-premises consumption.

b. For all other establishments, the following time frames apply for employment of an individual who is a certified food protection manager:

(1) For establishments newly licensed after January 1, 2014, the requirement of section 2-102.12 must be met within six months of licensure.

(2) Establishments in existence as of January 1, 2014, that do not receive a foodborne illness risk factor or public health intervention violation on or before July 1, 2017, shall meet the requirement of section 2-102.12 by January 1, 2018.

(3) Establishments in existence as of January 1, 2014, that receive a foodborne illness risk factor or public health intervention violation on or before July 1, 2017, shall meet the requirement of section 2-102.12 within six months of the violation.

(4) If the individual meeting the requirement of section 2-102.12 leaves employment with an establishment required to meet section 2-102.12, the establishment shall meet the requirement of section 2-102.12 within six months.

31.1(3) *Honey prepared in a residence.* Section 3-201.11 is amended to allow honey which is stored; prepared, including by placement in a container; or labeled at or distributed from the premises of a residence to be sold in a food establishment.

31.1(4) *Morel mushrooms.* Section 3-201.16, paragraph (A), is amended by adding the following:

"A food establishment or farmers market potentially hazardous food licensee may serve or sell morel mushrooms if procured from an individual who has completed a morel mushroom identification expert course. Every morel mushroom shall be identified and found to be safe by a certified morel mushroom identification expert whose competence has been verified and approved by the department through the expert's successful completion of a morel mushroom identification expert course provided by either an accredited college or university or a mycological society. The certified morel mushroom identification expert shall personally inspect each mushroom and determine it to be a morel mushroom. A morel mushroom identification expert course shall be at least three hours in length. To maintain status as a morel mushroom identification expert, the individual shall have successfully completed a morel mushroom identification expert course described above within the past three years. A person who wishes to offer a morel mushroom identification expert course must submit the course curriculum to the department for review and approval. Food establishments or farmers market potentially hazardous food licensees offering morel mushrooms shall maintain the following information for a period of 90 days from the date the morel mushrooms were obtained:

"1. The name, address, and telephone number of the morel mushroom identification expert;

"2. A copy of the morel mushroom identification expert's certificate of successful completion of the course, containing the date of completion; and

"3. The quantity of morel mushrooms purchased and the date(s) purchased.

"Furthermore, a consumer advisory shall inform consumers by brochures, deli case or menu advisories, label statements, table tents, placards, or other effective written means that wild mushrooms should be thoroughly cooked and may cause allergic reactions or other effects."

31.1(5) *Field-dressed wild game prohibition.* Subparagraph 3-201.17(A)(4) is amended to state that field-dressed wild game shall not be permitted in food establishments unless:

a. The food establishment is also licensed and inspected by the Iowa department of agriculture and land stewardship, meat and poultry inspection bureau, pursuant to Iowa Code section 189A.3;

b. All field-dressed wild game is adequately separated from food, equipment, utensils, clean linens, and single-service and single-use articles; and

c. Any equipment used in the processing of field-dressed wild game is adequately cleaned and sanitized before use with other foods.

31.1(6) *Reduced oxygen packaging in meat and poultry processing plants.* Meat and poultry processing plants that are licensed and inspected by the Iowa department of agriculture and land stewardship (IDALS) meat and poultry inspection bureau pursuant to Iowa Code section 189A.3 and that are also licensed as a food establishment are exempt from section 3-502.11, paragraphs (A), (B), (D) and (F), and section 3-502.12 if all of the following criteria are met:

a. Each food product formulation has been approved by the Iowa department of agriculture and land stewardship, meat and poultry inspection bureau;

b. A copy of the approved formulation (T40/45) is maintained on file at the establishment and made available to the regulatory authority upon request;

c. Cooked products that do not include a curing agent or an antimicrobial agent that will control Clostridium botulinum and Listeria monocytogenes that are in a reduced oxygen package are stored and sold frozen and are labeled "Keep Frozen"; and

d. The food products are properly labeled.

31.1(7) *Reduced oxygen packaging.* Section 3-502.12 is amended to include the following:

"A HACCP PLAN is not required when a FOOD ESTABLISHMENT packages raw meat and poultry using a REDUCED OXYGEN PACKAGING method and includes on the package a 30-day "sell by" date from the date the raw meat or poultry was packaged."

31.1(8) *Warewashing sinks in establishments serving alcoholic beverages.* Section 4-301.12 is amended by adding the following: "When alcoholic beverages are served in a food service establishment, a sink with not fewer than three compartments shall be used in the bar area for manual washing, rinsing and sanitizing of bar utensils and glasses. When food is served in a bar, a separate three-compartment sink for washing, rinsing and sanitizing food-related dishes shall be used in the kitchen area, unless a dishwasher is used to wash utensils."

31.1(9) *Allowance for two-compartment sinks in certain circumstances.* Paragraph 4-301.12(C) is amended by adding the following: "Establishments need not have a three-compartment sink when each of the following conditions is met:

"1. Three or fewer utensils are used for food preparation;

"2. Utensils are limited to tongs, spatulas, and scoops; and

"3. The department has approved after verification that the establishment can adequately wash and sanitize these utensils."

31.1(10) *Chemical treated towelettes.* Paragraph 5-203.11(C) is deleted.

31.1(11) *Service sink.* For existing establishments, if waste water is being appropriately disposed of, section 5-203.13 for existing establishments shall go into effect upon the establishment's renovation or sale.

31.1(12) *Toilets and lavatories.* Section 5-203.12 is amended by adding the following requirement: "Separate toilet facilities for men and women shall be provided in establishments which seat 50 or more people or in establishments which serve beer or alcoholic beverages."

31.1(13) *Backflow protection.* Section 5-203.14 is amended by adding the following: "Water outlets with hose attachments, except for water heater drains and clothes washer connections, shall be protected by a non-removable hose bibb backflow preventer or by a listed atmospheric vacuum breaker installed at least six inches above the highest point of usage and located on the discharge side of the last valve."

31.1(14) *Backflow prevention.* Paragraph 5-402.11(D) is amended by adding the following: "A culinary sink or sink used for food preparation shall not have a direct connection between the sewage system and a drain originating from that sink. Culinary sinks or sinks used in food preparation shall be separated by an air break."

31.1(15) *Inspection standards for elder group homes.* Elder group homes as defined by Iowa Code section 231B.1 shall be inspected by the department, but chapters 4 and 6 of the Food Code shall not apply. Elder group homes shall pay the lowest license fee set forth in 481—subrule 30.4(2).

31.1(16) *Nonprofit exception for temporary events.* Nonprofit organizations that are licensed as temporary food establishments may serve nonpotentially hazardous food from an unapproved source for the duration of the event.

31.1(17) *Variance approval by department and submission of HACCP plans.* Any variances or HACCP plans that require approval by the "regulatory authority" must be approved by the department. HACCP plans pursuant to paragraphs 3-502.12(B) and 8-201.13(B) shall be filed with the department prior to implementation, regardless of whether or not the plan requires approval.

31.1(18) *Trichinae control for pork products prepared at retail.* Pork products prepared at retail shall comply with the Code of Federal Regulations found in 9 CFR, Section 318.10, January 1, 2015, publication, regarding the destruction of possible live trichinae in pork and pork products. Examples of pork products that require trichinae control include raw sausages containing pork and other meat products, raw breaded pork products, bacon used to wrap around steaks and patties, and uncooked mixtures of pork and other meat products contained in meat loaves and similar types of products. The use of "certified pork" as authorized by the Iowa department of agriculture and land stewardship

or the United States Department of Agriculture, Food Safety and Inspection Service, shall meet the requirements of this subrule.

This rule is intended to implement Iowa Code section 137F.2.

[**ARC 1191C**, IAB 11/27/13, effective 1/1/14; **ARC 1928C**, IAB 4/1/15, effective 5/6/15; **ARC 2257C**, IAB 11/25/15, effective 12/30/15; **ARC 3188C**, IAB 7/5/17, effective 8/9/17 (see footnote 2 at end of chapter)]

481—31.2(137F) Inspection standards for food processing plants. The following are the inspection standards for food processing plants including food storage facilities.

31.2(1) *Definitions.* For the purposes of this rule, the following definitions shall apply. The definitions of "food," "label," "labeling," and "dietary supplement" are as defined in 21 U.S.C. Section 321 (2012).

31.2(2) *Prohibited acts.* The prohibited acts identified in 21 U.S.C. Section 331(a) to (f), (k), and (v) (2012) shall also be prohibited acts in Iowa.

31.2(3) *Stop sale.* Any article of food that is adulterated or misbranded when introduced into commerce may be embargoed until such a time as the adulteration of misbranding is remedied or the product is destroyed. The action is immediate, but the licensee may appeal the decision following the process outlined in rule 481—30.11(10A,137C,137D,137F).

31.2(4) *Standards for food.* If a standard that has been adopted for a food is adopted pursuant to 21 U.S.C. Section 341 (2012), the standard shall be met.

31.2(5) *Adulterated food.* See rule 481—31.3(137D,137F).

31.2(6) *Misbranded food.* A food shall be misbranded if it is found in violation of 21 U.S.C. Section 343 (2012).

31.2(7) *New dietary ingredients.* New dietary ingredients shall comply with the process in 21 U.S.C. Section 350(b) (2012) or shall be deemed adulterated.

31.2(8) *Records.* Records shall be made available at minimum to the extent required under 21 U.S.C. Section 373 (2012) for all interstate and intrastate food.

31.2(9) *Adoption of Code of Federal Regulations.* The following parts of the Code of Federal Regulations (April 1, 2017) are adopted:

a. 21 CFR Part 1, Sections 1.20 to 1.24 and Subpart O, Sections 1.900 to 1.934 (labeling).

b. 21 CFR Part 7, Sections 7.1 to 7.13 and 7.40 to 7.59 (guaranty and recalls).

c. 21 CFR Part 70, Sections 70.20 to 70.25 (labeling requirements for colors).

d. 21 CFR Part 73, Sections 73.1 to 73.615 (color additives exempt from certification).

e. 21 CFR Part 74.101 to 74.706 (listing of color additives subject to certification).

f. 21 CFR Part 81, general specifications and general restrictions for provisional color additives for use in foods, drugs, and cosmetics.

g. 21 CFR Part 82, Sections 82.3 to 82.706 (certified provisionally listed colors and specifications).

h. 21 CFR Part 100, Section 100.155 (specific provisions for salt and iodized salt).

i. 21 CFR Part 101, except Sections 101.69 and 101.108 (food labeling).

j. 21 CFR Part 102, except Section 102.19 (common or usual name for nonstandard food).

k. 21 CFR Part 104, nutritional quality guidelines for foods.

l. 21 CFR Part 105, food for special dietary use.

m. 21 CFR Part 106, except Section 106.120 (infant formula quality control procedures).

n. 21 CFR Part 107, except Sections 107.200 to 107.280 (infant formula labeling).

o. 21 CFR Part 108, Sections 108.25 to 108.35 (exceptions for when a permit is not required, acidified and thermal processing of low-acid foods packaged in hermetically sealed containers).

p. 21 CFR Part 109, unavoidable contaminants in food for human consumption and food-packaging material.

q. 21 CFR Part 110, current good manufacturing practice in manufacturing, packing or holding human food.

r. 21 CFR Part 111, current good manufacturing practice in manufacturing, packaging, labeling, or holding operations for dietary supplements.

s. 21 CFR Part 113, thermally processed low-acid food packaged in hermetically sealed containers.

t. 21 CFR Part 114, acidified foods.

u. 21 CFR Part 115, shell eggs.

v. 21 CFR Part 117, current good manufacturing practice and hazard analysis and risk-based preventive controls for human food, as follows:

(1) As of October 1, 2017, subparts A, B and F of 21 CFR 117 shall be in effect for all food processing plants.

(2) As of October 1, 2017, all other subparts of 21 CFR 117 shall be effective upon the effective date established by the federal government.

(3) As of October 1, 2018, qualified facilities, as defined in 21 CFR 117, shall not include food processing plants manufacturing foods for interstate commerce or as an ingredient to other foods.

w. 21 CFR Part 118, production, storage and transportation of shell eggs.

x. 21 CFR Part 120, hazard analysis and critical control point (HACCP) systems (juice).

y. 21 CFR Part 123, fish and fisheries products (seafood).

z. 21 CFR Part 129, processing and bottling of bottled drinking water.

aa. 21 CFR Part 130, except Sections 130.5, 130.6 and 130.17, food standards: general.

ab. 21 CFR Part 131, milk and cream.

ac. 21 CFR Part 133, cheeses and related cheese products.

ad. 21 CFR Part 135, frozen desserts.

ae. 21 CFR Part 136, bakery products.

af. 21 CFR Part 137, cereal flours and related products.

ag. 21 CFR Part 139, macaroni and noodle products.

ah. 21 CFR Part 145, canned fruits.

ai. 21 CFR Part 146, canned fruit juices.

aj. 21 CFR Part 150, fruit butters, jellies, preserves, and related products.

ak. 21 CFR Part 152, fruit pies.

al. 21 CFR Part 155 (canned vegetables).

am. 21 CFR Part 156, vegetable juices.

an. 21 CFR Part 158, frozen vegetables.

ao. 21 CFR Part 160, egg and egg products.

ap. 21 CFR Part 161, fish and shellfish.

aq. 21 CFR Part 163, cacao products.

ar. 21 CFR Part 164, tree nut and peanut products.

as. 21 CFR Part 165, beverages.

at. 21 CFR Part 166, margarine.

au. 21 CFR Part 168, sweeteners and table syrups.

av. 21 CFR Part 169, food dressings and flavorings.

aw. 21 CFR Part 170, except Sections 170.6, 170.15, and 170.17, food additives.

ax. 21 CFR Part 172, food additives permitted for direct addition to food for human consumption.

ay. 21 CFR Part 173, secondary direct food additives permitted in food for human consumption.

az. 21 CFR Part 174, indirect food additives: general.

ba. 21 CFR Part 175, indirect food additives: adhesives and components of coatings.

bb. 21 CFR Part 176, indirect food additives: paper and paperboard components.

bc. 21 CFR Part 177, indirect food additives: polymers.

bd. 21 CFR Part 178, indirect food additives: adjuvants, production aids, and sanitizers.

be. 21 CFR Part 180, food additives permitted in food or in contact with food on an interim basis pending additional study.

bf. 21 CFR Part 181, prior-sanctioned food ingredients.

bg. 21 CFR Part 182, substances generally recognized as safe.

bh. 21 CFR Part 184, direct food substances affirmed as generally recognized as safe.

bi. 21 CFR Part 186, indirect food substances affirmed as generally recognized as safe.

bj. 21 CFR Part 189, substances prohibited from use in human food.

bk. 21 CFR Part 190, dietary supplements.

31.2(10) *Egg products processing plants.* The department shall generally use the good manufacturing practices adopted in paragraph 31.2(9)*"b,"* unless such practices are inconsistent with standards set by the United States Department of Agriculture, Food Safety and Inspection Service, in 9 CFR Parts 590-592, January 1, 2015. If the standards are inconsistent, the standards adopted in 9 CFR Parts 590-592, January 1, 2015, apply.

31.2(11) *Specific requirements for the manufacture of packaged ice.* In addition to compliance with subrules 31.2(1) through 31.2(9), manufacturers of packaged ice must comply with the following:

a. Equipment must be cleaned on a schedule of frequency that prevents the accumulation of mold, fungus and bacteria. A formal cleaning program and schedule which include the use of sanitizers to eliminate microorganisms must be developed and used.

b. Packaged ice must be tested every 120 days for the presence of bacteria.

c. Plants that use a nonpublic water system must sample the water supply monthly for the presence of bacteria and annually for chemical and pesticide contamination as required by law.

This rule is intended to implement Iowa Code section 137F.2.

[**ARC 1191C**, IAB 11/27/13, effective 1/1/14; **ARC 1928C**, IAB 4/1/15, effective 5/6/15; **ARC 2257C**, IAB 11/25/15, effective 12/30/15; **ARC 3188C**, IAB 7/5/17, effective 8/9/17]

481—31.3(137D,137F) Adulterated food and disposal. No one may produce, distribute, offer for sale or sell adulterated food. "Adulterated" is defined in the federal Food, Drug and Cosmetic Act, Section 402. Adulterated food shall be disposed of in a reasonable manner as determined by the department. The destruction of adulterated food shall be watched by a person approved by the department.

This rule is intended to implement Iowa Code section 137F.2.

[**ARC 1191C**, IAB 11/27/13, effective 1/1/14]

481—31.4(137D,137F) False label or defacement. No person shall use any label required by Iowa Code chapter 137C or 137F which is deceptive as to the true nature of the article or place of production, or which has been carelessly printed or marked, nor shall any person erase or deface any label required by this chapter.

This rule is intended to implement Iowa Code sections 137D.2 and 137F.2.

[**ARC 1191C**, IAB 11/27/13, effective 1/1/14]

481—31.5(137F) Temporary food establishments and farmers market potentially hazardous food licensees. While the retail food code adopted in rule 481—31.1(137F) applies to temporary food establishments, the following subrules provide a simplified version of requirements for temporary food establishments. If the two rules are inconsistent, the standards in this rule apply.

31.5(1) *Personnel.* For the purposes of this rule, employees include volunteers.

a. Employees shall keep their hands and exposed portions of their arms clean.

b. Employees shall have clean garments and aprons and effective hair restraints. Smoking, eating or drinking in food booths is not allowed. All nonworking, unauthorized persons are to be kept out of the food booth.

c. All employees, including volunteers, shall be under the direction of the person in charge. The person in charge shall ensure that the workers are effectively cleaning their hands, that potentially hazardous food is adequately cooked, held or cooled, and that all multiuse equipment or utensils are adequately washed, rinsed and sanitized.

d. Employees and volunteers shall not work at a temporary food establishment or farmers market potentially hazardous food establishment if the employees and volunteers have open cuts, sores or communicable diseases. The person in charge shall take appropriate action to ensure that employees and volunteers who have a disease or medical condition transmissible by food are excluded from the food operation.

e. Every employee and volunteer must sign a logbook with the employee's or volunteer's name, address, and telephone number and the date and hours worked. The logbook must be maintained for 30 days by the person in charge and be made available to the department upon request.

31.5(2) *Food handling and service.*

a. *Dry storage.* All food, equipment, utensils and single-service items shall be stored off the ground and above the floor on pallets, tables or shelving.

b. *Cold storage.* Refrigeration units shall be provided to keep potentially hazardous foods at 41°F or below. The inspector may approve an effectively insulated, hard-sided container with sufficient coolant for storage of less hazardous food or the use of such a container at events of short duration if the container maintains the temperature at 41°F or below.

c. *Hot storage.* Hot food storage units shall be used to keep potentially hazardous food at 135°F or above. Electrical equipment is required for hot holding, unless the use of propane stoves and grills capable of holding the temperature at 135°F or above is approved by the department. Sterno cans are allowed for hot holding if adequate temperatures can be maintained. Steam tables or other hot holding devices are not allowed to heat foods and are to be used only for hot holding after foods have been adequately cooked.

d. *Cooking temperatures.* As specified in the following chart, the minimum cooking temperatures for food products are:

165°F	• Poultry and game animals that are not commercially raised • Products stuffed or in a stuffing that contains fish, meat, pasta, poultry or ratite • All products cooked in a microwave oven
155°F	• Rabbits, ratite and game meats that are commercially raised • Ground or comminuted (such as hamburgers) meat/fish products • Raw shell eggs not prepared for immediate consumption
145°F	• Pork and raw shell eggs prepared for immediate consumption • Fish and other meat products not requiring a 155°F or 165°F cooking temperature as listed above

e. *Consumer advisory requirement.* If raw or undercooked animal food such as beef, eggs, fish, lamb, poultry or shellfish is offered in ready-to-eat form, the license holder (person in charge) shall post the consumer advisory as required by the food code.

f. *Thermometers.* Each refrigeration unit shall have a numerically scaled thermometer to measure the air temperature of the unit accurately. An appropriate thermometer shall be provided where necessary to check the internal temperature of both hot and cold food. Thermometers must be accurate and have a range from 0°F to 220°F.

g. *Food display.* Foods on display must be covered. The public is not allowed to serve itself from opened containers of food or uncovered food items. Condiments such as ketchup, mustard, coffee creamer and sugar shall be served in individual packets or from squeeze containers or pump bottles. Milk shall be dispensed from the original container or from an approved dispenser. All fruits and vegetables must be washed before being used or sold. Food must be stored at least six inches off the ground. All cooking and serving areas shall be adequately protected from contamination. Barbeque areas shall be roped off or otherwise protected from the public. All food shall be protected from customer handling, coughing or sneezing by wrapping, sneeze guards or other effective means.

h. *Food preparation.* Unless otherwise approved by a variance from the department, no bare-hand contact of ready-to-eat food shall occur.

i. *Approved food source.* All food supplies shall come from a commercial manufacturer or an approved source. The use of food in hermetically sealed containers that is not prepared in an approved food processing plant is prohibited. Transport vehicles used to supply food products are subject to inspection and shall protect food from physical, chemical and microbial contamination.

j. *Leftovers.* Hot-held foods that are not used by the end of the day must be discarded.

31.5(3) *Utensil storage and warewashing.*

a. *Single-service utensils.* The use of single-service plates, cups and tableware is required.

b. Dishwashing. If approved, an adequate means to heat the water and a minimum of three basins large enough for complete immersion of the utensils are required to wash, rinse and sanitize utensils or food-contact equipment.

c. Sanitizers. Chlorine bleach or another approved sanitizer shall be provided for warewashing sanitization and wiping cloths. An appropriate test kit shall be provided to check the concentration of the sanitizer used. The person in charge shall demonstrate knowledge in the determination of the correct concentration of sanitizer to be used.

d. Wiping cloths. Wiping cloths shall be stored in a clean, 100 ppm chlorine sanitizing solution or equivalent. Sanitizing solution shall be changed as needed to maintain the solution in a clean condition.

31.5(4) *Water.*

a. Water supply. An adequate supply of clean water shall be provided from an approved source. Water storage units and hoses shall be food grade and approved for use in storage of water. If not permanently attached, hoses used to convey drinking water shall be clearly and indelibly identified as to their use. Water supply systems shall be protected against backflow or contamination of the water supply. Backflow prevention devices, if required, shall be maintained and adequate for their intended purpose.

b. Wastewater disposal. Wastewater shall be disposed of in an approved wastewater disposal system sized, constructed, maintained and operated according to law.

31.5(5) *Premises.*

a. Hand-washing container. An insulated container with at least a two-gallon capacity with a spigot, basin, soap and dispensed paper towels shall be provided for hand washing. The container shall be filled with hot water.

b. Floors, walls and ceilings. If required, walls and ceilings shall be of tight design and weather-resistant materials to protect against the elements and flying insects. If required, floors shall be constructed of tight wood, asphalt, rubber or plastic matting or other cleanable material to control dust or mud.

c. Lighting. Adequate lighting shall be provided. Lights above exposed food preparation areas shall be shielded.

d. Food preparation surfaces. All food preparation or food contact surfaces shall be of a safe design, smooth, easily cleanable and durable.

e. Garbage containers. An adequate number of cleanable containers with tight-fitting covers shall be provided both inside and outside the establishment.

f. Toilet rooms. An adequate number of approved toilet and hand-washing facilities shall be provided at each event.

g. Clothing. Personal clothing and belongings shall be stored at a designated place in the establishment, adequately separated from food preparation, food service and dishwashing areas.

This rule is intended to implement Iowa Code sections 137D.2 and 137F.2.

[**ARC 1191C**, IAB 11/27/13, effective 1/1/14]

[Filed 10/13/78, Notice 8/23/78—published 11/1/78, effective 12/7/78]
[Filed 4/23/82, Notice 3/17/82—published 5/12/82, effective 6/16/82]
[Filed 12/3/82, Notice 10/27/82—published 12/22/82, effective 1/26/83]
[Filed 9/21/84, Notice 8/15/84—published 10/10/84, effective 11/14/84]
[Filed 8/23/85, Notice 7/17/85—published 9/11/85, effective 10/16/85]
[Filed 1/25/85, Notice 12/19/84—published 2/13/85, effective 3/20/85]
[Filed 2/20/87, Notice 1/14/87—published 3/11/87, effective 4/15/87]
[Filed 8/6/87, Notice 7/1/87—published 8/26/87, effective 9/30/87]
[Filed 1/8/88, Notice 12/2/87—published 1/27/88, effective 3/2/88][1]
[Filed 1/22/88, Notice 12/16/87—published 2/10/88, effective 3/16/88]
[Filed 3/17/88, Notice 2/10/88—published 4/6/88, effective 5/11/88]
[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 8/5/88, Notice 6/29/88—published 8/24/88, effective 9/28/88]
[Filed 2/17/89, Notice 1/11/89—published 3/8/89, effective 4/12/89]

[Filed 10/27/89, Notice 8/23/89—published 11/15/89, effective 12/20/89]
[Filed 12/20/90, Notice 10/31/90—published 1/9/91, effective 2/13/91]
[Filed 4/12/91, Notice 3/6/91—published 5/1/91, effective 6/5/91]
[Filed 9/23/91, Notice 8/7/91—published 10/16/91, effective 11/20/91]
[Filed 4/22/92, Notice 3/18/92—published 5/13/92, effective 7/1/92]
[Filed 9/10/92, Notice 7/22/92—published 9/30/92, effective 11/4/92]
[Filed 11/3/94, Notice 9/14/94—published 11/23/94, effective 12/28/94]
[Filed 10/16/97, Notice 8/27/97—published 11/5/97, effective 12/10/97]
[Filed 1/21/99, Notice 12/16/98—published 2/10/99, effective 3/17/99]
[Filed 9/1/99, Notice 7/28/99—published 9/22/99, effective 10/27/99]
[Filed 7/5/00, Notice 5/31/00—published 7/26/00, effective 8/30/00]
[Filed 9/26/01, Notice 8/8/01—published 10/17/01, effective 11/21/01]
[Filed emergency 6/7/02—published 6/26/02, effective 6/7/02]
[Filed 3/21/08, Notice 12/5/07—published 4/9/08, effective 7/1/08]
[Filed emergency 7/24/08 after Notice 6/18/08—published 8/13/08, effective 7/24/08]
[Filed Emergency ARC 8696B, IAB 4/21/10, effective 4/1/10]
[Filed ARC 8856B (Notice ARC 8697B, IAB 4/21/10), IAB 6/16/10, effective 7/21/10]
[Filed ARC 1191C (Notice ARC 1025C, IAB 9/18/13), IAB 11/27/13, effective 1/1/14]
[Filed ARC 1928C (Notice ARC 1861C, IAB 2/4/15), IAB 4/1/15, effective 5/6/15]
[Filed ARC 2257C (Notice ARC 2171C, IAB 9/30/15), IAB 11/25/15, effective 12/30/15]
[Filed ARC 3188C (Notice ARC 3053C, IAB 5/10/17), IAB 7/5/17, effective 8/9/17][2]

[1] Rules 30—33.1(159) to 30—33.4(159) and 30—34.1(159) to 30—34.4(159) transferred to Inspections and Appeals Department[481] and rescinded.

[2] Rule 481—31.1(137F) published in the July 5, 2017, IAB as ARC 3188C has a January 1, 2018, effective date. For the rule in effect immediately prior to January 1, 2018, see 481—Chapter 31 as of June 21, 2017, which can be found at the following Web site: https://www.legis.iowa.gov/docs/iac/chapter/481.31.pdf.

CHAPTER 34
HOME BAKERIES

481—34.1(137D) Inspection standards.

34.1(1) All ingredients must come from a licensed or approved source except for fresh fruits and vegetables, nonhazardous baked goods and honey or eggs. The use of food in hermetically sealed containers not prepared in a licensed food processing plant is prohibited.

34.1(2) All food products and ingredients shall be stored in original containers. If removed from the original container, food and ingredients must be stored in labeled and closed containers. Container must be of a material that will not cause the food to become adulterated.

34.1(3) All food shall be in sound condition, free from spoilage, filth or other contamination and shall be safe for human consumption. Food products shall not be stored on the floor.

34.1(4) All potentially hazardous food must be refrigerated at 41°F or less to control bacterial growth.

34.1(5) Food storage facilities must be kept clean and located to protect food from unsanitary conditions or contamination from any source at all times.

34.1(6) The floors, walls, ceilings, utensils, machinery, equipment and supplies in the food preparation area and all vehicles used in the transportation of food must be kept thoroughly clean. All food contact surfaces shall be easy to clean, smooth, nonabsorbent, and free of cracks or open seams.

34.1(7) All food must be protected against insects and rodents at all times. Outside doors, windows, and other openings must be fitted with screens and self-closing doors, if not otherwise protected. No dogs, cats, or other pets are allowed in the room where food is prepared or stored.

34.1(8) All garbage and refuse must be kept in containers and removed from the premises regularly to eliminate insects and rodents, offensive odors, or health or fire hazards. Garbage and refuse containers must be durable, easy to clean, insect- and rodent-resistant and of material that neither leaks, nor absorbs liquid.

34.1(9) All food handlers must be free from contagious or communicable diseases, sores or infected wounds, and must keep their hair covered and restrained.

34.1(10) All food handlers must keep themselves and their clothing clean. Hands must be washed as frequently as necessary to maintain good sanitation.

34.1(11) Smoking is not permitted while handling or preparing food or in food preparation or storage areas.

34.1(12) All establishments must have an adequate supply of hot and cold potable water under pressure from an approved source. Facilities must ensure that equipment, utensils, and containers used in the preparation of food shall be washed, rinsed and sanitized. If the residence is not served by a public water system, the water must be tested annually for nitrites and coliform. Records of water tests must be maintained by license holders who are not served by a public system. These records must be available to the regulatory authority upon request.

34.1(13) All establishments must have proper toilet facilities, equipped with a hand-washing lavatory, complete with hot and cold potable water under pressure and hand soap. A supply of sanitary towels or a hand-drying device providing heated air shall be conveniently located near the hand-washing facility.

34.1(14) Rescinded IAB 9/22/99, effective 10/27/99.

[**ARC 3189C**, IAB 7/5/17, effective 8/9/17]

481—34.2(137D) Enforcement.

34.2(1) All violations shall be corrected within 90 days of an inspection. The license holder shall make a written report to the regulatory authority, stating the action taken to correct the violation.

34.2(2) Violation of these rules or any provision of Iowa Code chapter 137D is a simple misdemeanor. The department may employ various remedies if violations are discovered.

a. A license may be revoked.

b. An injunction may be sought.

c. A case may be referred to a county attorney for criminal prosecution.

d. Foods may be embargoed or a stop-sale order may be issued.

[**ARC 3189C**, IAB 7/5/17, effective 8/9/17]

481—34.3(137D) Labeling requirement. All labels shall contain the following information in legible English:

1. Name and address of the person(s) preparing the food,
2. Common name of the food,
3. The names of all ingredients in the food, beginning with the one present in the largest proportion and continuing in descending order of predominance, and
4. The quantity of the contents in terms of weight, measure or numerical count.

481—34.4(137D) Annual gross sales. Annual gross sales shall not exceed $35,000. The license holder shall maintain a record of sales of food licensed under Iowa Code section 137D.1(3). The record shall be available to the regulatory authority when requested.

[**ARC 3189C**, IAB 7/5/17, effective 8/9/17]

481—34.5(137D) Criminal offense—conviction of license holder.

34.5(1) The department may revoke the license of a license holder who:

a. Conducts an activity constituting a criminal offense in the licensed home bakery; and

b. Is convicted of a felony as a result.

34.5(2) The department may suspend or revoke the license of a license holder who:

a. Conducts an activity constituting a criminal offense in the licensed home bakery; and

b. Is convicted of a serious misdemeanor or aggravated misdemeanor as a result.

34.5(3) A certified copy of the final order or judgment of conviction or plea of guilty shall be conclusive evidence of the conviction of the license holder.

34.5(4) The department's decision to revoke or suspend a license may be contested by the adversely affected party pursuant to the provisions of 481—30.13(10A).

This rule is intended to implement Iowa Code section 137D.8(3).

[**ARC 3189C**, IAB 7/5/17, effective 8/9/17]

These rules are intended to implement Iowa Code chapter 137D.

[Filed emergency 6/9/88—published 6/29/88, effective 7/1/88]
[Filed 8/5/88, Notice 6/29/88—published 8/24/88, effective 9/28/88]
[Filed 4/12/91, Notice 3/6/91—published 5/1/91, effective 6/5/91]
[Filed 9/10/92, Notice 7/22/92—published 9/30/92, effective 11/4/92]
[Filed 9/1/99, Notice 7/28/99—published 9/22/99, effective 10/27/99]
[Filed 7/5/00, Notice 5/31/00—published 7/26/00, effective 8/30/00]
[Filed 3/21/08, Notice 12/5/07—published 4/9/08, effective 7/1/08]
[Filed ARC 3189C (Notice ARC 3051C, IAB 5/10/17), IAB 7/5/17, effective 8/9/17]

CHAPTER 102
SOCIAL GAMBLING

[Prior to 12/17/86, Revenue Department[730], Ch 93]
[Prior to 11/18/87, Racing and Gaming Division[195]]
[Prior to 6/14/89, Racing and Gaming Division[490], Ch 22]
[Prior to 9/5/90, see 481—Chapters 102 and 104]

Rescinded **ARC 3190C**, IAB 7/5/17, effective 8/9/17

CHAPTER 107
GAME NIGHTS

[Prior to 8/1/07, see 481—100.31(99B) and 481—100.60(99B) to 481—100.63(99B)]

Rescinded **ARC 3192C**, IAB 7/5/17, effective 8/9/17

PUBLIC HEALTH DEPARTMENT[641]

Rules of divisions under this department "umbrella" include Professional Licensure[645], Dental Board[650], Medical Board[653], Nursing Board[655] and Pharmacy Board[657]

CHAPTER 1
REPORTABLE DISEASES, POISONINGS AND CONDITIONS, AND QUARANTINE AND ISOLATION

1.1(139A) Definitions
1.2(139A) Purpose and authority

REPORTABLE COMMUNICABLE AND INFECTIOUS DISEASES

1.3(139A,141A) Reportable communicable and infectious diseases
1.4(135,139A) Reporting of reportable communicable and infectious diseases

REPORTABLE POISONINGS AND CONDITIONS—NONCOMMUNICABLE

1.5(139A,135) Reportable poisonings and conditions
1.6(135,139A) Reporting poisonings and conditions

INVESTIGATION

1.7(135,139A) Investigation of reportable diseases

ISOLATION AND QUARANTINE

1.8(139A) Isolation and quarantine
1.9(135,139A) Quarantine and isolation
1.10 and 1.11 Reserved
1.12(135,137,139A) Quarantine and isolation—model rule for local boards
1.13(135,139A) Area quarantine

SPECIFIC NONCOMMUNICABLE CONDITIONS

1.14(139A) Cancer
1.15(144) Congenital and inherited disorders
1.16(139A) Agriculturally related injury

CONFIDENTIALITY

1.17(139A,22) Confidentiality

STATE HYGIENIC LABORATORY

1.18(135,139A) Specimens for which the fee charged by the state hygienic laboratory shall be waived

CHAPTER 2
HEPATITIS PROGRAMS

VIRAL HEPATITIS PROGRAM—VACCINATIONS AND TESTING

2.1(135) Definitions
2.2(135) Purpose
2.3(135) Exposure risks for hepatitis C virus
2.4(135) Information for public distribution
2.5(135) Hepatitis vaccination and testing program
2.6 to 2.8 Reserved

HEPATITIS C AWARENESS PROGRAM—VETERANS

2.9(135) Definitions
2.10(135) Purpose
2.11(135) Awareness materials
2.12(135) Awareness information
2.13(135) Resources for hepatitis follow-up and treatment

CHAPTER 3
EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

EARLY HEARING DETECTION AND INTERVENTION (EHDI) PROGRAM

3.1(135) Definitions
3.2(135) Purpose
3.3(135) Goal and outcomes
3.4(135) Program components
3.5(135) Screening the hearing of all newborns
3.6(135) Procedures required of birthing hospitals
3.7(135) Procedures required of birth centers
3.8(135) Procedures to ensure that children born in locations other than a birth center or birthing hospital receive a hearing screening
3.9(135) Reporting hearing screening results and information to the department and child's primary care provider
3.10(135) Conducting and reporting screening results and diagnostic audiologic assessments to the department and child's primary care provider
3.11(135) Sharing of information and confidentiality
3.12 Reserved
3.13(135) Procedure to accommodate parental objection
3.14(135) Civil/criminal liability
3.15(135) Early hearing detection and intervention advisory committee
3.16 Reserved

HEARING AIDS AND AUDIOLOGIC SERVICES FUNDING PROGRAM

3.17(83GA,HF811) Eligibility criteria
3.18(83GA,HF811) Covered services
3.19(83GA,HF811) Application procedures
3.20(83GA,HF811) Hearing aids and audiologic services funding wait list
3.21(83GA,HF811) Reimbursement of providers
3.22(83GA,HF811) Appeals

CHAPTER 4
CENTER FOR CONGENITAL AND INHERITED DISORDERS

4.1(136A) Program overview
4.2(136A) Definitions
4.3(136A) Iowa newborn screening program (INSP)
4.4(136A) Iowa maternal prenatal screening program (IMPSP)
4.5(136A) Regional genetic consultation service (RGCS)
4.6(136A) Neuromuscular and other related genetic disease program (NMP)
4.7(136A) Iowa registry for congenital and inherited disorders (IRCID)
4.8(135) Iowa's early hearing detection and intervention program
4.9 and 4.10 Reserved

CENTER FOR CONGENITAL AND INHERITED DISORDERS ADVISORY COMMITTEE (CIDAC)

4.11(136A) Purpose
4.12(136A) Duties of the committee
4.13(136A) Membership
4.14(136A) Meetings

CHAPTER 5
MATERNAL DEATHS

5.1(135) Reporting of maternal deaths
5.2(135) Ascertainment of maternal deaths
5.3(135) Reviewing of maternal deaths

CHAPTER 6
Reserved

CHAPTER 7
IMMUNIZATION AND IMMUNIZATION EDUCATION: PERSONS ATTENDING ELEMENTARY OR SECONDARY SCHOOLS, LICENSED CHILD CARE CENTERS OR INSTITUTIONS OF HIGHER EDUCATION

7.1(139A) Definitions
7.2(139A) Persons included
7.3(139A) Persons excluded
7.4(139A) Required immunizations
7.5(139A) Required education
7.6(139A) Proof of immunization
7.7(139A) Provisional enrollment
7.8(139A) Records and reporting
7.9(139A) Providing immunization services
7.10(139A) Compliance
7.11(22) Statewide registry
7.12(22) Release of immunization and health screening information

CHAPTER 8
IOWA CARE FOR YOURSELF (IA CFY) PROGRAM

8.1(135) Definitions
8.2(135) Components of the Iowa care for yourself (IA CFY) program
8.3(135) Participant eligibility criteria
8.4(135) Participant application procedures for IA CFY program services
8.5(135) Priority for program expenditures
8.6(135) Right to appeal
8.7(135) Verification for the breast or cervical cancer treatment (BCCT) option of Medicaid

CHAPTER 9
OUTPATIENT DIABETES EDUCATION PROGRAMS

9.1(135) Scope
9.2(135) Definitions
9.3(135) Powers and duties
9.4(135) Application procedures for American Diabetes Association-recognized and American Association of Diabetes Educators-accredited programs
9.5(135) Renewal procedures for American Diabetes Association-recognized and American Association of Diabetes Educators-accredited programs
9.6(135) Application procedures for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators
9.7(135) Diabetes program management for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators
9.8(135) Program staff for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators

9.9(135) Renewal application procedures for programs not recognized by the American Diabetes Association or accredited by the American Association of Diabetes Educators
9.10(135) Annual report
9.11(135) Enforcement
9.12(135) Complaints
9.13(135) Appeal process
9.14(135) Formal contest

CHAPTER 10
IOWA GET SCREENED: COLORECTAL CANCER PROGRAM

10.1(135) Purpose
10.2(135) Definitions
10.3(135) Components of the Iowa get screened (IGS): colorectal cancer program
10.4 Reserved
10.5(135) Participant eligibility criteria
10.6(135) Participant application procedures for IGS program services
10.7(135) Priority for program expenditures
10.8(135) Right to appeal
10.9(135) Colorectal cancer treatment

CHAPTER 11
HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION AND ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

11.1(139A,141A) Definitions
11.2(141A) HIV testing—obtaining consent—voluntary HIV-related tests for adults who are not pregnant
11.3(139A,141A) HIV testing—obtaining consent—voluntary HIV-related tests for minors who are not pregnant
11.4(141A) HIV testing—obtaining consent—voluntary HIV-related tests for pregnant women
11.5(141A) HIV test results—post-test counseling
11.6(141A) Reporting of diagnoses and HIV-related tests, events, and conditions to the department
11.7(141A) Penalties
11.8(141A) Immunity
11.9 and 11.10 Reserved

TRAINING PROGRAMS

11.11(135) Purpose
11.12 to 11.14 Reserved

PARTNER NOTIFICATION SERVICES AND DIRECT NOTIFICATION OF AN IDENTIFIABLE THIRD PARTY

11.15(139A,141A) Purpose
11.16(139A,141A) Definitions
11.17(139A,141A) Partner notification services by the department
11.18(141A) Direct notification of an identifiable third party by a physician or the department
11.19 and 11.20 Reserved

CARE PROVIDERS EXPOSED TO CONTAGIOUS OR INFECTIOUS DISEASES

11.21(139A) Purpose
11.22(139A) Definitions
11.23(139A,141A) Exposures in non-clinical settings
11.24(139A,141A) Exposures in clinical settings
11.25(139A) Immunity

11.26(139A) Duty to test
11.27 to 11.29 Reserved

HIV-RELATED TEST FOR CONVICTED OR ALLEGED SEXUAL-ASSAULT OFFENDERS AND VICTIMS

11.30(915) Purpose
11.31(915) Definitions
11.32(915) HIV-related test—convicted or alleged sexual assault offender
11.33(915) Medical examination costs
11.34(915) Testing, reporting, and counseling—penalties
11.35 to 11.39 Reserved

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

11.40(141A) Definitions
11.41(141A) Purpose
11.42(141A) Ensuring payer of last resort
11.43(141A) Eligibility requirements
11.44(141A) Enrollment process
11.45(141A) Discontinuation of services
11.46(141A) Distribution requirements
11.47(141A) ADAP waiting list
11.48(141A) Appeals
11.49(141A) Confidentiality

CHAPTER 12
APPROVAL OF CONFIRMATORY LABORATORIES FOR
PRIVATE SECTOR DRUG-FREE WORKPLACE TESTING

12.1(730) Purpose
12.2(730) Definitions
12.3(730) Powers and duties
12.4(730) Application procedures and requirements
12.5(730) Requirements of laboratory personnel involved in confirmatory testing for alcohol or other drugs, or their metabolites
12.6(730) Quality assurance program and procedure manual requirements
12.7(730) Analytical quality control
12.8(730) Sample security and confidentiality of test results
12.9(730) Confirmatory testing
12.10(730) Documentation of the confirmatory testing process
12.11(730) Reporting of confirmed positive test results to the medical review officer
12.12(730) Reporting requirements to department
12.13(730) Approval, renewal, and inspection fees
12.14(730) Renewal
12.15(730) Reciprocity
12.16(730) Changes during approval periods
12.17(730) Enforcement
12.18(730) Denial, suspension, modification or revocation of approval
12.19(730) Restoration of approval
12.20(730) Appeals process
12.21(730) Complaints

CHAPTER 13
Reserved

CHAPTER 14
WATER TREATMENT SYSTEMS

14.1(714)	Purpose
14.2(714)	Applicability
14.3(714)	Definitions
14.4(714)	Performance testing
14.5(714)	Third-party testing agencies
14.6(714)	Registration
14.7(714)	Label and manufacturer's performance data sheet
14.8(714)	Consumer information pamphlet
14.9(714)	Sales of water treatment systems
14.10(714)	Treatment of records
14.11(714)	Penalties

CHAPTER 15
SWIMMING POOLS AND SPAS

15.1(135I)	Applicability
15.2(135I)	Scope
15.3(135I)	Definitions and abbreviations

SWIMMING POOLS

15.4(135I)	Swimming pool operations
15.5(135I)	Construction and reconstruction

ADMINISTRATION

15.6(135I)	Enforcement
15.7(135I)	Variances
15.8(135I)	Penalties
15.9(135I)	Registration
15.10(135I)	Training courses
15.11(135I)	Swimming pool/spa operator qualifications
15.12(135I)	Fees
15.13(135I)	28E agreements
15.14(135I)	Application denial or partial denial—appeal
15.15 to 15.50	Reserved

SPAS

15.51(135I)	Spa operations
15.52(135I)	Construction and reconstruction

CHAPTERS 16 to 19
Reserved

CHAPTER 20
COMMUNITY WATER FLUORIDATION GRANT PROGRAM

20.1(135)	Purpose
20.2(135)	Definitions
20.3(135)	Applications
20.4(135)	Review and rating of applications
20.5(135)	Project contracts
20.6(135)	Implementation procedures
20.7(135)	Reimbursement
20.8(135)	Termination
20.9(135)	Appeals

CHAPTER 21
CENTRAL REGISTRY FOR
BRAIN AND SPINAL CORD INJURIES

21.1(135) Purpose
21.2(135) Definitions
21.3(135) Reportable brain and spinal cord injuries
21.4(135) Who reports and under what circumstances
21.5(135) Method and frequency of reporting
21.6(135) Confidentiality
21.7(135) Quality assurance

CHAPTER 22
PRACTICE OF TATTOOING

22.1(135) Purpose
22.2(135) Definitions
22.3(135) General provisions
22.4(135) Sanitation and infection control
22.5(135) Equipment
22.6(135) Procedures
22.7(135) Permit issuance and renewal
22.8(135) Fees
22.9(135) Tattoo establishment permit requirements
22.10(135) Tattoo artist permit requirements
22.11(135) Temporary establishment permit requirements
22.12(135) Mobile tattoo unit permit requirements
22.13(135) Agreements
22.14(135) Inspection requirements
22.15(135) Tattoo inspector qualifications
22.16(135) Enforcement
22.17(135) Adverse actions and the appeal process

CHAPTER 23
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSEE PRACTICE

23.1(105) Definitions
23.2(105) Duties of all licensees, specialty licensees, and certificate holders
23.3(105) Contractor license
23.4(105) Master license
23.5(105) Journeyperson license
23.6(105) Apprentice license
23.7(105) Specialty licenses and certifications
23.8(105) Inactive license

CHAPTER 24
PRIVATE WELL TESTING, RECONSTRUCTION, AND
PLUGGING—GRANTS TO COUNTIES

24.1(135) Applicability
24.2(135) Definitions
24.3(135) Eligibility
24.4(135) Goal and objectives
24.5(135) Eligible grant costs
24.6(135) Ineligible grant costs
24.7(135) Performance requirements
24.8(135) Contents of grant application

24.9(135) Grant application submission
24.10(135) Multicounty grant applications
24.11(135) Grant period
24.12 Reserved
24.13(135) Grant amendments
24.14(135) Termination or forfeiture of grant funds

CHAPTER 25
STATE PLUMBING CODE

25.1(105) Adoption
25.2(105) Applicability
25.3(105) Fuel gas piping
25.4(105) Amendments to Uniform Plumbing Code
25.5(105) Backflow prevention with containment

CHAPTER 26
BACKFLOW PREVENTION ASSEMBLY TESTER REGISTRATION

26.1(135K) Applicability
26.2(135K) Definitions
26.3(135K) Registration required
26.4(135K) Backflow prevention assembly tester training
26.5(135K) Registration
26.6(135K) Standards of conduct
26.7(135K) Penalty
26.8(135K) Denial, probation, suspension or revocation

CHAPTER 27
PLUMBING AND MECHANICAL SYSTEMS BOARD—ADMINISTRATIVE AND REGULATORY AUTHORITY

27.1(17A,105) Definitions
27.2(17A,105) Purpose of board
27.3(17A,105) Organization of board and proceedings
27.4(17A,105) Official communications
27.5(17A,105) Office hours
27.6(21) Public meetings

CHAPTER 28
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSURE FEES

28.1(105) Fees
28.2(105) Annual review of fee schedule

CHAPTER 29
PLUMBING AND MECHANICAL SYSTEMS BOARD—APPLICATION, LICENSURE, AND EXAMINATION

29.1(105) Definitions
29.2(105) Available licenses and general requirements
29.3(105) Medical gas piping certification
29.4(105) Minimum qualifications for licensure
29.5(105) General requirements for application for licensure
29.6(105) Examination
29.7(105) License renewal
29.8(105) License reissue
29.9(105) Waiver from examination for military service

29.10(105) Reactivation of an inactive license
29.11(105) Review of applications
29.12(105) Grounds for denial of an application

CHAPTER 30
CONTINUING EDUCATION FOR PLUMBING AND MECHANICAL SYSTEMS PROFESSIONALS

30.1(105) Definitions
30.2(105) Continuing education requirements
30.3(105) Continuing education programs/activities
30.4(105) Course instructor(s)
30.5(105) Compliance review of continuing education requirements
30.6(105) Continuing education exemptions
30.7(105) Continuing education extensions
30.8(105) Continuing education reporting requirements

CHAPTER 31
PLUMBING AND MECHANICAL SYSTEMS BOARD—WAIVERS OR VARIANCES FROM ADMINISTRATIVE RULES

31.1(17A,105,272C) Definitions
31.2(17A,105,272C) Scope of chapter
31.3(17A,105,272C) Applicability of chapter
31.4(17A,105,272C) Criteria for waiver or variance
31.5(17A,105,272C) Filing of petition
31.6(17A,105,272C) Content of petition
31.7(17A,105,272C) Additional information
31.8(17A,105,272C) Notice
31.9(17A,105,272C) Hearing procedures
31.10(17A,105,272C) Ruling
31.11(17A,105,272C) Public availability
31.12(17A,105,272C) Summary reports
31.13(17A,105,272C) Cancellation of a waiver
31.14(17A,105,272C) Violations
31.15(17A,105,272C) Defense
31.16(17A,105,272C) Judicial review

CHAPTER 32
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSEE DISCIPLINE

32.1(105,272C) Definitions
32.2(105,272C) Grounds for discipline
32.3(105,272C) Method of discipline
32.4(272C) Discretion of board
32.5(105) Civil penalties
32.6(105,272C) Collection of delinquent civil penalties and discipline-related debts

CHAPTER 33
PLUMBING AND MECHANICAL SYSTEMS BOARD—CONTESTED CASES

33.1(17A,105,272C) Scope and applicability
33.2(17A,105,272C) Definitions
33.3(17A) Time requirements
33.4(17A,272C) Probable cause
33.5(17A,272C) Informal settlement
33.6(17A) Statement of charges

33.7(17A) Requests for contested case proceeding
33.8(105) Legal representation
33.9(17A,105,272C) Presiding officer in a disciplinary contested case
33.10(17A) Presiding officer in a nondisciplinary contested case
33.11(17A) Disqualification
33.12(17A) Consolidation—severance
33.13(17A) Pleadings
33.14(17A) Service and filing
33.15(17A) Discovery
33.16(17A,272C) Subpoenas in a contested case
33.17(17A) Motions
33.18(17A) Withdrawals
33.19(17A) Intervention
33.20(17A) Telephone proceedings
33.21(17A) Prehearing conferences
33.22(17A) Continuances
33.23(272C) Settlement agreements
33.24(17A) Hearing procedures
33.25(17A) Evidence
33.26(17A) Default
33.27(17A) Ex parte communication
33.28(17A) Recording costs
33.29(17A) Interlocutory appeals
33.30(17A,272C) Decisions
33.31(17A,272C) Client notification
33.32(17A,272C) Application for rehearing
33.33(17A) Stays of board actions
33.34(17A) No factual dispute contested cases
33.35(17A) Emergency adjudicative proceedings
33.36(17A,105,272C) License denial
33.37(17A,105,272C) Denial of application to renew license
33.38(105,272C) Recovery of hearing fees and expenses
33.39(17A) Judicial review
33.40(17A,272C) Reinstatement

CHAPTER 34
PLUMBING AND MECHANICAL SYSTEMS BOARD—COMPLAINTS AND INVESTIGATIONS
34.1(272C) Complaints
34.2(272C) Report of malpractice claims or actions or disciplinary actions
34.3(272C) Report of acts or omissions
34.4(272C) Investigation of complaints or reports
34.5(17A,272C) Issuance of investigatory subpoenas
34.6(272C) Peer review committees
34.7(17A) Appearance

CHAPTER 35
PLUMBING AND MECHANICAL SYSTEMS BOARD—LICENSURE OF NONRESIDENT APPLICANT—RECIPROCITY
35.1(105) Definition
35.2(105) Reciprocity agreements
35.3(105) Application by reciprocity

CHAPTER 36
PLUMBING AND MECHANICAL SYSTEMS BOARD—PETITIONS FOR RULE MAKING

36.1(17A) Petition for rule making
36.2(17A) Briefs
36.3(17A) Inquiries
36.4(17A) Board consideration

CHAPTER 37
PHYSICAL PROTECTION OF CATEGORY 1 AND CATEGORY 2 QUANTITIES OF RADIOACTIVE MATERIAL

GENERAL PROVISIONS

37.1(136C) Purpose and scope
37.2 to 37.4 Reserved
37.5(136C) Definitions
37.6 Reserved
37.7(136C) Communications
37.8 to 37.10 Reserved
37.11(136C) Specific exemptions
37.12 to 37.20 Reserved

BACKGROUND INVESTIGATIONS AND ACCESS CONTROL PROGRAM

37.21(136C) Personnel access authorization requirements for category 1 or category 2 quantities of radioactive material
37.22 Reserved
37.23(136C) Access authorization program requirements
37.24 Reserved
37.25(136C) Background investigations
37.26 Reserved
37.27(136C) Requirements for criminal history records checks of individuals granted unescorted access to category 1 or category 2 quantities of radioactive material
37.28 Reserved
37.29(136C) Relief from fingerprinting, identification, and criminal history records checks and other elements of background investigations for designated categories of individuals permitted unescorted access to certain radioactive materials
37.30 Reserved
37.31(136C) Protection of information
37.32 Reserved
37.33(136C) Access authorization program review
37.34 to 37.40 Reserved

PHYSICAL PROTECTION REQUIREMENTS DURING USE

37.41(136C) Security program
37.42 Reserved
37.43(136C) General security program requirements
37.44 Reserved
37.45(136C) LLEA coordination
37.46 Reserved
37.47(136C) Security zones
37.48 Reserved
37.49(136C) Monitoring, detection, and assessment
37.50 Reserved
37.51(136C) Maintenance and testing

37.52 Reserved
37.53(136C) Requirements for mobile devices
37.54 Reserved
37.55(136C) Security program review
37.56 Reserved
37.57(136C) Reporting of events
37.58 to 37.70 Reserved

PHYSICAL PROTECTION IN TRANSIT

37.71(136C) Additional requirements for transfer of category 1 and category 2 quantities of radioactive material
37.72 Reserved
37.73(136C) Applicability of physical protection of category 1 and category 2 quantities of radioactive material during transit
37.74 Reserved
37.75(136C) Preplanning and coordination of shipment of category 1 or category 2 quantities of radioactive material
37.76 Reserved
37.77(136C) Advance notification of shipment of category 1 quantities of radioactive material
37.78 Reserved
37.79(136C) Requirements for physical protection of category 1 and category 2 quantities of radioactive material during shipment
37.80 Reserved
37.81(136C) Reporting of events
37.82 to 37.100 Reserved

RECORDS

37.101(136C) Form of records
37.102 Reserved
37.103(136C) Record retention
37.104 Reserved
37.105(136C) Inspections

CHAPTER 38
GENERAL PROVISIONS FOR RADIATION MACHINES
AND RADIOACTIVE MATERIALS

38.1(136C) Purpose and scope
38.2(136C) Definitions
38.3(136C) Exemptions from the regulatory requirements
38.4(136C) General regulatory requirements
38.5 Reserved
38.6(136C) Prohibited uses
38.7(136C) Communications
38.8(136C) Fees
38.9(136C) Administrative enforcement actions
38.10(136C) Deliberate misconduct

CHAPTER 39
REGISTRATION OF RADIATION MACHINE FACILITIES, LICENSURE OF RADIOACTIVE
MATERIALS AND TRANSPORTATION OF RADIOACTIVE MATERIALS

39.1(136C) Purpose and scope
39.2(136C) Definitions
39.3(136C) Requirements for registration of X-ray and other electronic machines that produce radiation

39.4(136C) Requirements for licensing of radioactive materials
39.5(136C) Transportation of radioactive material

CHAPTER 40
STANDARDS FOR PROTECTION AGAINST RADIATION

GENERAL PROVISIONS
40.1(136C) Purpose and scope
40.2(136C) Definitions
40.3(136C) Implementation
40.4 to 40.9 Reserved

RADIATION PROTECTION PROGRAMS
40.10(136C) Radiation protection programs
40.11 to 40.14 Reserved

OCCUPATIONAL DOSE LIMITS
40.15(136C) Occupational dose limits for adults
40.16(136C) Compliance with requirements for summation of external and internal doses
40.17(136C) Determination of external dose from airborne radioactive material
40.18(136C) Determination of internal exposure
40.19(136C) Determination of prior occupational dose
40.20(136C) Planned special exposures
40.21(136C) Occupational dose limits for minors
40.22(136C) Dose equivalent to an embryo/fetus
40.23 to 40.25 Reserved

RADIATION DOSE LIMITS FOR INDIVIDUAL MEMBERS OF THE PUBLIC
40.26(136C) Dose limits for individual members of the public
40.27(136C) Compliance with dose limits for individual members of the public

RADIOLOGICAL CRITERIA FOR LICENSE TERMINATION
40.28(136C) Radiological criteria for license termination
40.29(136C) Radiological criteria for unrestricted use
40.30(136C) Criteria for license termination under restricted conditions
40.31(136C) Alternate criteria for license termination

TESTING FOR LEAKAGE OR CONTAMINATION OF SEALED SOURCES
40.32(136C) Testing for leakage or contamination of sealed sources
40.33 to 40.35 Reserved

SURVEYS AND MONITORING
40.36(136C) Surveys and monitoring—general
40.37(136C) Conditions requiring individual monitoring of external and internal occupational dose
40.38 to 40.41 Reserved

CONTROL OF EXPOSURE FROM EXTERNAL SOURCES IN RESTRICTED AREAS
40.42(136C) Control of access to high radiation areas
40.43(136C) Control of access to very high radiation areas
40.44(136C) Control of access to very high radiation areas—irradiators
40.45 to 40.47 Reserved

RESPIRATORY PROTECTION AND CONTROLS TO RESTRICT INTERNAL EXPOSURE IN RESTRICTED AREAS
40.48(136C) Use of process or other engineering controls
40.49(136C) Use of other controls
40.50(136C) Use of individual respiratory protection equipment

40.51 to 40.53 Reserved

STORAGE AND CONTROL OF LICENSED OR REGISTERED SOURCES OF RADIATION

40.54 Reserved
40.55(136C) Security and control of licensed or registered sources of radiation
40.56(136C) Control of sources of radiation not in storage
40.57 to 40.59 Reserved

PRECAUTIONARY PROCEDURES

40.60(136C) Caution signs
40.61(136C) Posting requirements
40.62(136C) Exceptions to posting requirements
40.63(136C) Labeling containers and radiation machines
40.64(136C) Exemptions to labeling requirements
40.65(136C) Procedures for receiving and opening packages
40.66 to 40.69 Reserved

WASTE DISPOSAL

40.70(136C) General requirements
40.71(136C) Method for obtaining approval of proposed disposal procedures
40.72(136C) Disposal by release into sanitary sewerage
40.73(136C) Treatment or disposal by incineration
40.74(136C) Disposal of specific wastes
40.75(136C) Transfer for disposal and manifests
40.76(136C) Compliance with environmental and health protection regulations
40.77(136C) Disposal of certain by-product material
40.78 and 40.79 Reserved

RECORDS

40.80(136C) General provisions
40.81(136C) Records of radiation protection programs
40.82(136C) Records of surveys
40.83(136C) Records of tests for leakage or contamination of sealed sources
40.84(136C) Records of prior occupational dose
40.85(136C) Records of planned special exposures
40.86(136C) Records of individual monitoring results
40.87(136C) Records of dose to individual members of the public
40.88(136C) Records of waste disposal
40.89(136C) Records of testing entry control devices for very high radiation areas
40.90(136C) Form of records
40.91 to 40.94 Reserved

REPORTS

40.95(136C) Reports of stolen, lost, or missing licensed or registered sources of radiation
40.96(136C) Notification of incidents
40.97(136C) Reports of exposures, radiation levels, and concentrations of radioactive material exceeding the constraints or limits
40.98(136C) Reports of planned special exposures
40.99(136C) Reports of transactions involving nationally tracked sources
40.100(136C) Reports of individual monitoring
40.101(136C) Notifications and reports to individuals
40.102(136C) Reports of leaking or contaminated sealed sources
40.103 and 40.104 Reserved

ADDITIONAL REQUIREMENTS

40.105(136C) Vacating premises
40.106 to 40.109 Reserved

NOTICES, INSTRUCTIONS, AND REPORTS TO WORKERS; INSPECTIONS

40.110(136C) Posting of notices to workers
40.111(136C) Instructions to workers
40.112(136C) Notifications and reports to individuals
40.113(136C) Presence of representatives of licensees or registrants and workers during inspection
40.114(136C) Consultation with workers during inspections
40.115(136C) Requests by workers for inspections
40.116(136C) Inspections not warranted—informal review
40.117(136C) Employee protection

CHAPTER 41
SAFETY REQUIREMENTS FOR THE USE OF
RADIATION MACHINES AND CERTAIN USES
OF RADIOACTIVE MATERIALS

41.1(136C) X-rays in the healing arts
41.2(136C) Use of radionuclides in the healing arts
41.3(136C) Therapeutic use of radiation machines
41.4 and 41.5 Reserved
41.6(136C) X-ray machines used for screening and diagnostic mammography
41.7(136C) X-ray machines used for stereotactically guided breast biopsy

CHAPTER 42
PERMIT TO OPERATE IONIZING RADIATION PRODUCING MACHINES
OR ADMINISTER RADIOACTIVE MATERIALS

42.1(136C) Purpose
42.2(136C) Definitions
42.3(136C) Exemptions

PERMIT APPLICATION AND RENEWAL

42.4(136C) Permit application and renewal
42.5(136C) Permit to practice as a general radiologic technologist
42.6(136C) Permit to practice as a general nuclear medicine technologist
42.7(136C) Permit to practice as a radiation therapist
42.8(136C) Permit to practice as a radiologist assistant
42.9(136C) Permit to practice as a limited radiologic technologist with categories of chest, spine, extremities, shoulder, pediatric
42.10(136C) Permit to practice as an X-ray equipment operator in either podiatric radiography or bone densitometry
42.11 Reserved
42.12(136C) Closed classification or category permits
42.13(136C) Combining permits for an individual qualifying for permits in more than one classification
42.14 to 42.17 Reserved

PERMIT HOLDER SUBMISSION OF CONTINUING EDUCATION

42.18(136C) Submission of proof of completion of continuing education by permit holder to meet continuing education requirements to renew or reinstate a permit
42.19 and 42.20 Reserved

ADMINISTRATIVE ITEMS AND GROUNDS FOR DISCIPLINARY ACTION

42.21(136C) Administrative items
42.22(136C) Rules of conduct, self-reporting requirements, and enforcement actions for all permit holders
42.23(136C) Procedures for demand for information, notice of proposed action, and orders for penalties, suspensions, revocations, and civil penalties for all individuals under this chapter
42.24 and 42.25 Reserved

DEPARTMENT APPROVAL OF CONTINUING EDUCATION ACTIVITIES

42.26(136C) Department approval of continuing education activities
42.27 to 42.29 Reserved

FORMAL EDUCATION

42.30(136C) Requirements for formal education
42.31(136C) Standards for formal education for limited radiologic technologists
42.32(136C) Standards for formal education for X-ray equipment operators in podiatric radiography
42.33(136C) Standards for formal education for X-ray equipment operators in bone densitometry

CHAPTER 43
MINIMUM REQUIREMENTS FOR RADON TESTING AND ANALYSIS

43.1(136B) Purpose and scope
43.2(136B) Definitions
43.3(136B) General provisions
43.4(136B) Application for certification
43.5(136B) Enforcement actions
43.6(136B) Reporting requirements
43.7(136B) Training and continuing education programs
43.8(136B) Exemptions
43.9(136B) Enforcement
43.10(136B) Penalties
43.11(136B) Persons exempted from certification

CHAPTER 44
MINIMUM REQUIREMENTS FOR RADON MITIGATION

44.1(136B) Purpose and scope
44.2(136B) Definitions
44.3(136B) General provisions
44.4(136B) Application for credentialing
44.5(136B) Revocation of credentialing
44.6(136B) Additional record-keeping requirements
44.7(136B) Continuing education
44.8(136B) Exemptions
44.9(136B) Enforcement
44.10(136B) Penalties

CHAPTER 45
RADIATION SAFETY REQUIREMENTS FOR INDUSTRIAL RADIOGRAPHIC OPERATIONS

45.1(136C) General requirements for industrial radiography operations
45.2(136C) Radiation safety requirements for the use of radiation machines in industrial radiography

45.3(136C) Radiation safety requirements for use of sealed sources of radiation in industrial radiography
45.4(136C) Radiation safety requirements for the use of particle accelerators for nonhuman use
45.5(136C) Radiation safety requirements for analytical X-ray equipment
45.6(136C) Radiation safety requirements for well-logging, wireline service operations and subsurface tracer studies

CHAPTER 46
MINIMUM REQUIREMENTS FOR TANNING FACILITIES
46.1(136D) Purpose and scope
46.2(136D) Definitions
46.3(136D) Exemptions
46.4(136D) Permits and fees
46.5(136D) Construction and operation of tanning facilities
46.6(136D) Inspections, violations and injunctions

CHAPTERS 47 to 49
Reserved

CHAPTER 50
ORAL HEALTH
50.1(135) Purpose
50.2(135) Definitions
50.3(135) Dental director responsibilities
50.4(135) Oral health bureau functions
50.5(135) Funding

CHAPTER 51
DENTAL SCREENING
51.1(135) Purpose
51.2(135) Definitions
51.3(135) Persons included
51.4(135) Persons excluded
51.5(135) Dental screening components
51.6(135) Dental screening providers
51.7(135) Time line for valid dental screening
51.8(135) Proof of dental screening
51.9(135) Dental screening documentation
51.10(135) Assuring dental screening services
51.11(135) Records
51.12(135) Reporting
51.13(135) Iowa's dental screening database
51.14(135) Release of dental screening information
51.15(135) Referral requirements
51.16(135) Provider training

CHAPTER 52
VISION SCREENING
52.1(135) Purpose
52.2(135) Definitions
52.3(135) Persons included and persons excluded
52.4(135) Child vision screening components
52.5(135) Time line for valid vision screening

52.6(135) Proof of child vision screening
52.7(135) Child vision screening reporting
52.8(135) School requirements
52.9(135) Iowa's child vision screening database module and follow-up
52.10(135) Referral requirements

CHAPTERS 53 and 54
Reserved

CHAPTER 55
ADVISORY COUNCIL ON BRAIN INJURIES

55.1(135) Definitions
55.2(135) Mission of council
55.3(135) Council established
55.4(135) Officers
55.5(135) Duties of the council
55.6(135) Meetings
55.7(135) Minutes
55.8(135) Task forces
55.9(135) Expenses of advisory council members

CHAPTER 56
BRAIN INJURY SERVICES PROGRAM

56.1(135) Definitions
56.2(135) Purpose
56.3(135) Waiver-eligible component
56.4(135) Cost-share component
56.5(135) Application process
56.6(135) Service providers and reimbursement
56.7(135) Available services/service plan
56.8(135) Redetermination
56.9(135) Appeal rights

CHAPTER 57
PLUMBING AND MECHANICAL SYSTEMS BOARD—
DECLARATORY ORDERS

57.1(17A) Petition for declaratory order
57.2(17A) Notice of petition
57.3(17A) Intervention
57.4(17A) Briefs
57.5(17A) Inquiries
57.6(17A) Service and filing of petitions and other papers
57.7(17A) Consideration
57.8(17A) Action on petition
57.9(17A) Refusal to issue order
57.10(17A) Contents of declaratory order—effective date
57.11(17A) Copies of orders
57.12(17A) Effect of a declaratory order

CHAPTER 58
PLUMBING AND MECHANICAL SYSTEMS BOARD—AGENCY PROCEDURE FOR RULE MAKING

58.1(17A) Applicability
58.2(17A) Advice on possible rules before notice of proposed rule adoption
58.3(17A) Public rule-making docket
58.4(17A) Notice of proposed rule making
58.5(17A) Public participation
58.6(17A) Regulatory analysis
58.7(17A) Fiscal impact statement
58.8(17A) Time and manner of rule adoption
58.9(17A) Variance between adopted rule and published notice of proposed rule adoption
58.10(17A) Exemptions from public rule-making procedures
58.11(17A) Concise statement of reasons
58.12(17A) Contents, style, and form of rule
58.13(17A) Agency rule-making record
58.14(17A) Filing of rules
58.15(17A) Effectiveness of rules prior to publication
58.16(17A) General statements of policy
58.17(17A) Review by agency of rules

CHAPTER 59
PLUMBING AND MECHANICAL SYSTEMS BOARD—FAIR INFORMATION PRACTICES AND PUBLIC RECORDS

59.1(17A,22) Definitions
59.2(17A,22) Statement of policy
59.3(17A,22) Requests for access to records
59.4(17A,22) Access to confidential records
59.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination
59.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
59.7(17A,22) Consent to disclosure by the subject of a confidential record
59.8(17A,22) Notice to suppliers of information
59.9(17A,22) Disclosures without the consent of the subject
59.10(17A,22) Routine use
59.11(17A,22) Consensual disclosure of confidential records
59.12(17A,22) Release to subject
59.13(17A,22) Availability of records
59.14(17A,22) Personally identifiable information
59.15(17A,22) Other groups of records routinely available for public inspection
59.16(17A,22) Applicability

CHAPTER 60
PLUMBING AND MECHANICAL SYSTEMS BOARD—NONCOMPLIANCE REGARDING CHILD SUPPORT, NONPAYMENT OF STATE DEBT, AND NONCOMPLIANCE REGARDING STUDENT LOAN REPAYMENT

60.1(252J) Child support noncompliance
60.2(272D) Nonpayment of state debt
60.3(261) Student loan repayment noncompliance

CHAPTER 61
STATE MECHANICAL CODE

61.1(105) Definitions
61.2(105) Adoption by reference
61.3(105) Hospitals and health care facilities
61.4(105) Enforcement

CHAPTER 62
PLUMBING AND MECHANICAL SYSTEMS BOARD—
MILITARY SERVICE AND VETERAN RECIPROCITY

62.1(85GA,ch1116) Military service and veteran reciprocity

CHAPTERS 63 to 66
Reserved

CHAPTER 67
BLOOD LEAD TESTING

67.1(135) Purpose
67.2(135) Definitions
67.3(135) Persons included
67.4(135) Persons excluded
67.5(135) Blood lead testing requirement
67.6(135) Time line for valid blood lead testing
67.7(135) Proof of blood lead testing
67.8(135) Referral requirements
67.9(135) Blood lead testing documentation
67.10(135) Records
67.11(135) Provider training

CHAPTER 68
CONTROL OF LEAD-BASED PAINT HAZARDS

68.1(135) Applicability
68.2(135) Definitions
68.3(135) Elevated blood lead (EBL) inspections required
68.4(135) Refusal of admittance
68.5(135) Lead hazard reduction required
68.6(135) Retaliation prohibited
68.7(135) Enforcement
68.8(135) Hearings
68.9(135) Variances
68.10(135) Injunction
68.11(135) Effective date

CHAPTER 69
RENOVATION, REMODELING, AND REPAINTING—
LEAD HAZARD NOTIFICATION PROCESS

69.1(135) Applicability
69.2(135) Definitions
69.3(135) Notification required in target housing
69.4(135) Notification required in multifamily housing
69.5(135) Emergency renovation, remodeling, or repainting in target housing
69.6(135) Certification of attempted delivery in target housing
69.7(135) Notification required in child-occupied facilities

69.8(135) Emergency renovation, remodeling, or repainting in child-occupied facilities
69.9(135) Certification of attempted delivery for child-occupied facilities
69.10(135) Subcontracts
69.11(135) Exemption
69.12(135) Record-keeping requirements
69.13(135) Compliance inspections
69.14(135) Enforcement
69.15(135) Waivers

CHAPTER 70
LEAD-BASED PAINT ACTIVITIES

70.1(135) Applicability
70.2(135) Definitions
70.3(135) Lead professional certification
70.4(135) Course approval and standards
70.5(135) Certification, interim certification, and recertification
70.6(135) Work practice standards for lead professionals conducting lead-based paint activities in target housing and child-occupied facilities
70.7(135) Firms
70.8 Reserved
70.9(135) Compliance inspections
70.10(135) Denial, suspension, or revocation of certification; denial, suspension, revocation, or modification of course approval; and imposition of penalties
70.11(135) Waivers

CHAPTER 71
EMERGENCY INFORMATION SYSTEM ON PESTICIDES FOR USE BY HEALTH CARE PROVIDERS DURING MEDICAL EMERGENCIES

71.1(139A) Scope
71.2(139A) Definitions
71.3(139A) Operation of EIS

CHAPTER 72
CHILDHOOD LEAD POISONING
PREVENTION PROGRAM

72.1(135) Definitions
72.2(135) Approved programs
72.3(135) Level of funding
72.4(135) Appeals

CHAPTER 73
SPECIAL SUPPLEMENTAL NUTRITION PROGRAM
FOR WOMEN, INFANTS, AND CHILDREN (WIC)

73.1(135) Program explanation
73.2(135) Adoption by reference
73.3(135) Availability of rules and policy and procedure manual
73.4(135) Definitions
73.5(135) Staffing of contract agencies
73.6(135) Certification of participants
73.7(135) Food delivery
73.8(135) Food package
73.9(135) Education
73.10(135) Health services

73.11(135) Appeals and fair hearings—local agencies
73.12(135) Right to appeal—participant
73.13(135) Right to appeal—vendor
73.14(135) State monitoring of contract agencies
73.15(135) Migrant services
73.16(135) Civil rights
73.17(135) Audits
73.18(135) Reporting
73.19(135) WIC program violation
73.20(135) Data processing
73.21(135) Outreach
73.22(135) Caseload management
73.23(135) Grant application procedures for contract agencies
73.24(135) Participant rights
73.25(135) Confidentiality

CHAPTER 74
FAMILY PLANNING SERVICES

74.1(135) Program explanation
74.2(135) Adoption by reference
74.3(135) Rule coverage
74.4(135) Definitions
74.5(135) Grant application procedures for contract agencies
74.6(135) Funding levels for contract agencies
74.7(135) Agency performance
74.8(135) Reporting
74.9(135) Fiscal management
74.10(135) Audits
74.11(135) Denial, suspension, revocation, or reduction of contracts with contract agencies
74.12(135) Right to appeal—contract agency

CHAPTER 75
STATEWIDE OBSTETRICAL AND
NEWBORN INDIGENT PATIENT CARE PROGRAM

75.1(255A) Definitions
75.2(255A) Covered services
75.3(255A) Quota assignment
75.4(255A) Eligibility criteria
75.5(255A) Application procedures
75.6(255A) Reimbursement of providers
75.7(255A) Reassignment of county quotas
75.8(255A) Appeals and fair hearings

CHAPTER 76
MATERNAL AND CHILD HEALTH PROGRAM

76.1(135) Program overview
76.2(135) Adoption by reference
76.3(135) Rule coverage
76.4(135) Definitions
76.5(135) MCH services
76.6(135) Client eligibility criteria
76.7(135) Client application procedures for MCH services
76.8(135) Right to appeal—client

76.9(135) Grant application procedures for community-based contract agencies
76.10(135) Funding levels for community-based contract agencies
76.11(135) Contract agency performance
76.12(135) Reporting
76.13(135) Fiscal management
76.14(135) Audits
76.15 Reserved
76.16(135) Denial, suspension, revocation or reduction of contracts with contract agencies
76.17(135) Right to appeal—contract agency
76.18 to 76.20 Reserved

MATERNAL AND CHILD HEALTH ADVISORY COUNCIL

76.21(135) Purpose
76.22(135) Mission
76.23(135) Membership
76.24(135) Officers
76.25(135) Duties of the council
76.26(135) Meetings
76.27(135) Executive committee
76.28(135) Committees

CHAPTER 77
LOCAL BOARDS OF HEALTH

77.1(137) Purpose
77.2(137) Definitions
77.3(137) Local boards of health—roles and responsibilities
77.4(137) Organization of local boards of health
77.5(137) Operation of local boards of health
77.6(137) Expenses of local board of health members
77.7(137) Dissolution of city boards
77.8(137) Request to form district board of health
77.9(137) Review, approval or denial of district board of health formation
77.10(137) Adding to a district board of health
77.11(137) Withdrawal from a district board of health

CHAPTERS 78 and 79
Reserved

CHAPTER 80
LOCAL PUBLIC HEALTH SERVICES

80.1(135) Purpose
80.2(135) Definitions
80.3(135) Local public health services (LPHS)
80.4(135) Utilization of LPHS contract funding
80.5(135) Right to appeal
80.6(135) Community capacity/local board of health and healthy aging funds

CHAPTER 81
GENERAL RULES FOR MIGRATORY LABOR CAMPS

81.1(138) Shelters
81.2(138) Water supply
81.3(138) Waste disposal
81.4(138) Bathing facilities

81.5(138) Central dining facilities
81.6(138) Safety and fire

CHAPTER 82
OFFICE OF MINORITY AND MULTICULTURAL HEALTH

82.1(135) Purpose
82.2(135) Definitions
82.3(135) Responsibilities of the office of minority and multicultural health
82.4(135) Advisory council

CHAPTERS 83 and 84
Reserved

CHAPTER 85
LOCAL SUBSTITUTE MEDICAL DECISION-MAKING BOARDS

85.1(135) Purpose
85.2(135) Definitions
85.3(135) Appointment of local boards
85.4(135) Filing an application
85.5(135) Notification of patient and review of application
85.6(135) Panel appointment and procedures
85.7(135) Panel determination of need for surrogate decision making
85.8(135) Panel determination regarding proposed medical care decision
85.9(135) Right of appeal
85.10(135) Records and reports
85.11(135) Liability

CHAPTER 86
PLACES WHERE DEAD HUMAN BODIES ARE PREPARED
FOR BURIAL OR ENTOMBMENT

86.1(156) Purpose
86.2(156) Definitions
86.3(156) Licensing
86.4(156) Public access areas
86.5(156) Preparation room
86.6(156) Crematorium chambers
86.7(156) Inspection fees

CHAPTER 87
HEALTHY FAMILIES IOWA (HFI)

87.1(135) Purpose
87.2(135) Definitions
87.3(135) Applicant eligibility
87.4(135) Participant eligibility
87.5(135) Program requirements
87.6(135) Contractor assurance
87.7(135) Applicant appeal process
87.8(135) Participant right to appeal

CHAPTER 88
VOLUNTEER HEALTH CARE PROVIDER PROGRAM

88.1(135) Purpose
88.2(135) Definitions
88.3(135) Eligibility for the volunteer health care provider program

88.4(135) Sponsor entity and protected clinic
88.5(135) Covered health care services
88.6(135) Defense and indemnification
88.7(135) Term of agreement
88.8(135) Reporting requirements and duties
88.9(135) Revocation of agreement
88.10(135) Procedure for revocation of agreement
88.11(135) Effect of suspension or revocation
88.12(135) Protection denied
88.13(135) Board notice of disciplinary action
88.14(135) Effect of eligibility protection
88.15(135) Reporting by a protected clinic or sponsor entity

CHAPTER 89
DECISION-MAKING ASSISTANCE PROGRAM
AND PARENTAL NOTIFICATION OF INTENT
TO TERMINATE A PREGNANCY THROUGH ABORTION

89.1(135L) Title
89.2(135L) Purpose and scope
89.3(135L) Definitions
89.4 to 89.10 Reserved

DECISION-MAKING ASSISTANCE PROGRAM

89.11(135L) Purpose
89.12(135L) Initial appointment of a pregnant minor with a licensed physician from whom an abortion is sought and certification procedure for the decision-making assistance program
89.13 to 89.20 Reserved

NOTIFICATION PROCESS

89.21(135L) Notification of parent prior to the performance of abortion on a pregnant minor
89.22(135L) Exceptions to notification of parent
89.23(135L) Physician compliance
89.24 and 89.25 Reserved
89.26(135L) Fraudulent practice

CHAPTER 90
IOWA CHILD DEATH REVIEW TEAM

90.1(135) Purpose
90.2(135) Definitions
90.3(135) Agency
90.4(135) Membership
90.5(135) Officers
90.6(135) Meetings
90.7(135) Expenses of team members
90.8(135) Team responsibilities
90.9(135) Liaisons
90.10(135) Confidentiality and disclosure of information
90.11(135) Immunity and liability

CHAPTER 91
IOWA DOMESTIC ABUSE DEATH REVIEW TEAM

91.1(135) Purpose
91.2(135) Definitions

91.3(135) Agency
91.4(135) Membership
91.5(135) Officers
91.6(135) Meetings
91.7(135) Expenses of team members
91.8(135) Team duties and responsibilities
91.9(135) Liaisons
91.10(135) Confidentiality and disclosure of information
91.11(135) Immunity and liability

CHAPTER 92
IOWA FATALITY REVIEW COMMITTEE

92.1(135) Purpose
92.2(135) Definitions
92.3(135) Committee
92.4(135) Formation of the committee
92.5(135) Committee protocol for review
92.6(135) Content of report
92.7(135) Consultation with county attorney
92.8(135) Supplemental report
92.9(135) Confidentiality and disclosure of information
92.10(135) Immunity and liability

CHAPTER 93
MANDATORY REPORTER TRAINING CURRICULA

93.1(135) Purpose
93.2 and 93.3 Reserved
93.4(135) Duties
93.5(135) Standards for approval of curricula
93.6(135) Process for application review and approval
93.7(135) Process for appeal

CHAPTER 94
CHILD PROTECTION CENTER GRANT PROGRAM

94.1(135) Scope and purpose
94.2(135) Definitions
94.3(135) Goals
94.4(135) Review process
94.5(135) Eligibility and criteria
94.6(135) Appeals

CHAPTER 95
VITAL RECORDS: GENERAL ADMINISTRATION

95.1(144) Definitions
95.2(144) Vital records and statistics
95.3(144) Forms—property of department
95.4(144) Information by others
95.5(144) Handling of vital records
95.6(144) Fees
95.7(144) General public access of vital records in the custody of the county registrar
95.8(144) Direct tangible interest in and entitlement to a vital record
95.9(144) Search and issuance of a certified copy of a vital record
95.10(144) Search and issuance for genealogy or family history

95.11(144) Registrars' responsibility for maintenance of confidentiality
95.12(144) Disclosure of data
95.13(144) Preparation of certified copies
95.14(144) Cancellation of fraudulent records
95.15(144) Unlawful acts
95.16(144) Enforcement assistance

CHAPTER 96
BIRTH REGISTRATION

96.1(144) Definitions
96.2(144) Forms—property of department
96.3(144) Standard birth registration—up to seven days
96.4(144) Standard birth registration—seven days to one year
96.5(144) Birthing institutions
96.6(144) Non-birthing institutions
96.7(144) Non-institution birth
96.8(144) Gestational surrogate arrangement birth registration
96.9(144) Foundling birth registration
96.10(144) Newborn safe haven registration
96.11(144) Birth registration following a foreign-born adoption
96.12(144) Birth registration fees
96.13(144) Fee collection
96.14(144) Waivers
96.15(144) Fee deposit
96.16(144) Responsibilities of institutions
96.17(144) Responsibility for births occurring in non-institutions and non-birthing institutions
96.18(144) Delayed birth registration—one year or more after event

CHAPTER 97
DEATH REGISTRATION AND DISPOSITION OF DEAD HUMAN BODIES

97.1(144) Definitions
97.2(144) Forms—property of department
97.3(144) Standard registration of death—up to one year
97.4(144) Standard registration of fetal death—up to one year
97.5(144) Preparation of the certificate of death or fetal death
97.6(144) Medical certification of death
97.7(144) Medical certification of fetal death
97.8(144) Medical certifier
97.9(144) Report of autopsy findings
97.10(144) Extension of time
97.11(144) Removal of a dead human body or fetus
97.12(144) Burial-transit permit
97.13(144) Transportation and disposition of a dead human body or fetus
97.14(144) Disinterment permits
97.15(144) Delayed death registration—one year or more after event
97.16(144) Registration of presumptive death
97.17(144) Release or final disposition of a dead human body or fetus by an institution
97.18(144) Additional record by funeral director

CHAPTER 98
MARRIAGE REGISTRATION

98.1(144,595) Definitions
98.2(144,595) Forms—property of department

98.3(144,595) Standard registration of marriage—up to one year
98.4(144,595) Application for a license to marry in Iowa
98.5(144,595) License to marry
98.6(144, 595) Certificate of marriage
98.7(144,595) Delayed registration of marriage—one year or more after date of event
98.8(144,595) Dissolution of marriage or annulment

CHAPTER 99
VITAL RECORDS MODIFICATIONS

99.1(144) Definitions
99.2(144) Forms—property of department
99.3(144) Forms used in the establishment of new records
99.4(144) Corrections of minor error in vital record—within one year of event
99.5(144) Amendment of certificate of live birth to add first or middle given name—within one year of event
99.6(144) Amendment of vital record—one year or more after the event
99.7(144) Method of amendment of vital records
99.8(144) Correction or amendment of same item more than once
99.9(144) Other amendments to certificate of live birth
99.10(144) Correction or amendment to medical certification of cause of death
99.11(144) Correction or amendment to a certificate of marriage
99.12(144) Correction to a report of dissolution of marriage or annulment
99.13(144) Minimum information required to establish a new certificate of live birth
99.14(144) Establishment of new certificate of live birth following adoption
99.15(144) Establishment of new certificate of live birth following a birth by gestational surrogate arrangement
99.16(144) Certificate of live birth following voluntary paternity affidavit
99.17(144) Certificate of live birth following court determination of paternity
99.18(144) Certificate of live birth following recision of paternity affidavit or disestablishment of paternity
99.19(144) Certificate of live birth following court-ordered change of name
99.20(144) Certificate of live birth following sex designation change

CHAPTER 100
VITAL RECORDS REGISTRIES AND REPORTS

100.1(144) Definitions
100.2(144) Forms—property of department
100.3(144) Declaration of paternity registry established
100.4(144) Mutual consent voluntary adoption registry established
100.5(144) Statistical report of termination of pregnancy report

CHAPTERS 101 to 106
Reserved

CHAPTER 107
BOARD-CERTIFIED BEHAVIOR ANALYST AND BOARD-CERTIFIED ASSISTANT BEHAVIOR ANALYST (BCBA/BCaBA) GRANTS PROGRAM

107.1(135) Scope and purpose
107.2(135) Definitions
107.3(135) Eligibility criteria
107.4(135) Priority in grant awards
107.5(135) Amount of a grant
107.6(135) Use of funds

107.7(135) Review process
107.8(135) Reporting

CHAPTER 108
MEDICAL RESIDENCY TRAINING STATE MATCHING GRANTS PROGRAM

108.1(135) Scope and purpose
108.2(135) Definitions
108.3(135) Eligibility criteria
108.4(135) Amount of grant
108.5(135) Review process

CHAPTER 109
PRESCRIPTION DRUG DONATION REPOSITORY PROGRAM

109.1(135M) Definitions
109.2(135M) Purpose
109.3(135M) Eligibility criteria for program participation by medical facilities and pharmacies
109.4(135M) Standards and procedures for accepting donated prescription drugs and supplies
109.5(135M) Standards and procedures for inspecting and storing donated prescription drugs and supplies
109.6(135M) Standards and procedures for dispensing donated prescription drugs and supplies
109.7(135M) Eligibility criteria for individuals to receive donated prescription drugs and supplies
109.8(135M) Forms and record keeping
109.9(135M) Handling fee
109.10(135M) List of drugs and supplies program will accept
109.11(135M) Exemption from disciplinary action, civil liability and criminal prosecution
109.12 and 109.13 Reserved
109.14(135M) Prescription drug donation repository in disaster emergencies

CHAPTER 110
CENTER FOR RURAL HEALTH
AND PRIMARY CARE

110.1(135) Purpose and scope
110.2(135) Definitions
110.3(135) Responsibilities of the center
110.4(135) Advisory committee to the center for rural health and primary care
110.5(135) Organization
110.6(135) Meetings
110.7 to 110.10 Reserved

PRIMECARRE COMMUNITY GRANT PROGRAM

110.11(135) Purpose
110.12 to 110.15 Reserved

PRIMECARRE PRIMARY CARE PROVIDER
COMMUNITY SCHOLARSHIP PROGRAM

110.16(135) Purpose
110.17 to 110.20 Reserved

PRIMECARRE PRIMARY CARE PROVIDER LOAN REPAYMENT PROGRAM

110.21(135) Purpose

CHAPTER 111
IOWA NEEDS NURSES NOW INFRASTRUCTURE ACCOUNT

111.1(135) Scope and purpose
111.2(135) Definitions

111.3(135) Eligibility and criteria
111.4(135) Review process
111.5(135) Performance standards
111.6(135) Appeals

CHAPTER 112
BIOLOGICAL AGENT RISK ASSESSMENT
112.1(135) Purpose
112.2(135) Definitions
112.3(135) Biosecurity council established
112.4(135) Biological agent risk assessment
112.5(135) Requests for biological agent information
112.6(135) Exceptions

CHAPTER 113
PUBLIC HEALTH RESPONSE TEAMS
113.1(135) Definitions
113.2(135) Purpose
113.3(135) Sponsor agency
113.4(135) Public health response team members
113.5(135) Public health response team
113.6(135) Legal and other protections
113.7(135) Reporting requirements and duties

CHAPTER 114
PREPAREDNESS ADVISORY COMMITTEE
114.1(135) Definitions
114.2(135) Purpose
114.3(135) Appointment and membership
114.4(135) Officers
114.5(135) Meetings
114.6(135) Subcommittees
114.7(135) Expenses of preparedness advisory committee voting members
114.8(135) Committee composition

CHAPTERS 115 to 121
Reserved

CHAPTER 122
ANATOMICAL GIFT PUBLIC AWARENESS AND TRANSPLANTATION FUND
122.1(142C) Scope and purpose
122.2(142C) Definitions
122.3(142C) State agencies or nonprofit legal entities
122.4(142C) Hospitals
122.5(142C) Transplant recipients and donors

CHAPTER 123
Reserved

CHAPTER 124
INTERAGENCY COORDINATING COUNCIL
FOR THE STATE MEDICAL EXAMINER
124.1(691) Purpose
124.2(691) Membership

124.3(691) Meetings
124.4(691) Duties
124.5(691) Minutes

CHAPTER 125
ADVISORY COUNCIL FOR THE STATE MEDICAL EXAMINER

125.1(691) Purpose
125.2(691) Membership
125.3(691) Meetings
125.4(691) Duties
125.5(691) Minutes

CHAPTER 126
STATE MEDICAL EXAMINER

126.1(144,331,691) Definitions
126.2 Reserved
126.3(691) Fees for autopsies and related services and reimbursement for related expenses
126.4(691) Fees for tissue recovery

CHAPTER 127
COUNTY MEDICAL EXAMINERS

127.1(144,331,691) Definitions
127.2(331,691) Duties of medical examiners—jurisdiction over deaths which affect the public interest
127.3(331,691) Autopsies
127.4(331,691) Fees
127.5(144,331,691) Death certificates—deaths affecting the public interest
127.6(331,691) Cremation
127.7(331,691) County medical examiner investigators
127.8(331,691) Deputy county medical examiners
127.9(331,691) Failure to comply with rules
127.10(331,691,22) Confidentiality
127.11(331,691,670) Indemnification

CHAPTERS 128 and 129
Reserved

CHAPTER 130
EMERGENCY MEDICAL SERVICES ADVISORY COUNCIL

130.1(147A) Definitions
130.2(147A) Purpose
130.3(147A) Appointment and membership
130.4(147A) Officers
130.5(147A) Meetings
130.6(147A) Subcommittees
130.7(147A) Expenses of advisory council members
130.8(147A) Council composition

CHAPTER 131
EMERGENCY MEDICAL SERVICES—PROVIDER
EDUCATION/TRAINING/CERTIFICATION

131.1(147A) Definitions
131.2(147A) Emergency medical care providers—requirements for enrollment in training programs

131.3(147A) Emergency medical care providers—authority
131.4(147A) Emergency medical care providers—certification, renewal standards, procedures, continuing education, and fees
131.5(147A) Training programs—standards, application, inspection and approval
131.6(147A) Continuing education providers—approval, record keeping and inspection
131.7(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of emergency medical care personnel certificates or renewal
131.8(147A) Complaints and investigations—denial, citation and warning, probation, suspension, or revocation of training program approval or renewal
131.9(147A) Reinstatement of certification
131.10(147A) Certification denial
131.11(147A) Emergency adjudicative proceedings
131.12(147A) Complaints, investigations and appeals

CHAPTER 132
EMERGENCY MEDICAL SERVICES—SERVICE PROGRAM AUTHORIZATION

132.1(147A) Definitions
132.2(147A) Authority of emergency medical care provider
132.3 to 132.6 Reserved
132.7(147A) Service program—authorization and renewal procedures, inspections and transfer or assignment of certificates of authorization
132.8(147A) Service program levels of care and staffing standards
132.9(147A) Service program—off-line medical direction
132.10(147A) Complaints and investigations—denial, citation and warning, probation, suspension or revocation of service program authorization or renewal
132.11 to 132.13 Reserved
132.14(147A) Temporary variances
132.15(147A) Transport options for fully authorized EMT-P, PS, and paramedic service programs

CHAPTER 133
WHITE FLASHING LIGHT AUTHORIZATION

133.1(321) Definitions
133.2(321) Purpose
133.3(321) Application
133.4(321) Approval, denial, probation, suspension and revocation of authorization
133.5(321) Appeal of denial, probation, or revocation of authorization

CHAPTER 134
TRAUMA CARE FACILITY CATEGORIZATION
AND VERIFICATION

134.1(147A) Definitions
134.2(147A) Trauma care facility categorization and verification
134.3(147A) Complaints and investigations and appeals—denial, citation and warning, probation, suspension, and revocation of verification as a trauma care facility

CHAPTER 135
TRAUMA TRIAGE AND TRANSFER PROTOCOLS

135.1(147A) Definitions
135.2(147A) Trauma triage and transfer protocols
135.3(147A) Offenses and penalties

CHAPTER 136
TRAUMA REGISTRY

136.1(147A) Definitions
136.2(147A) Trauma registry
136.3(147A) Offenses and penalties

CHAPTER 137
TRAUMA EDUCATION AND TRAINING

137.1(147A) Definitions
137.2(147A) Initial trauma education for Iowa's trauma system
137.3(147A) Continuing trauma education for Iowa's trauma system
137.4(147A) Offenses and penalties

CHAPTER 138
TRAUMA SYSTEM ADVISORY COUNCIL

138.1(147A) Definitions
138.2(147A) Purpose and duties
138.3(147A) Appointment and membership
138.4(147A) Officers
138.5(147A) Meetings
138.6(147A) Subcommittees
138.7(147A) Confidentiality
138.8(147A) Documentation
138.9(147A) Expenses of advisory council members
138.10(147A) Council composition

CHAPTER 139
IOWA LAW ENFORCEMENT EMERGENCY CARE PROVIDER

139.1(147A) Definitions
139.2(147A) Authority of Iowa law enforcement emergency care provider
139.3(147A) Iowa law enforcement emergency care providers—requirements for enrollment in training programs
139.4(147A) Iowa law enforcement emergency care providers—certification, renewal standards and procedures, and fees
139.5(147A) Iowa law enforcement training programs
139.6(147A) Law enforcement AED service program authorization

CHAPTER 140
EMERGENCY MEDICAL SERVICES SYSTEM DEVELOPMENT GRANTS FUND

140.1(135) Definitions
140.2(135) Purpose
140.3(135) County EMS associations
140.4(135) County EMS system development grants

CHAPTER 141
LOVE OUR KIDS GRANT

141.1(321) Definitions
141.2(321) Purpose
141.3(321) Funding limitations
141.4(321) Use of funds
141.5(321) Application process
141.6(321) Application denial—appeal

CHAPTER 142
OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDERS

142.1(144A) Definitions
142.2(144A) Purpose
142.3(144A,147A) Responsibilities of the department
142.4(144A,147A) EMS providers
142.5(144A) Guidelines for non-EMS health care providers, patients, and organizations
142.6(144A) Revocation of the out-of-hospital do-not-resuscitate order
142.7(144A) Personal wishes of family members or other individuals who are not authorized to act on the patient's behalf
142.8(144A) Transfer of patients
142.9(144A) Application to existing orders

CHAPTER 143
AUTOMATED EXTERNAL DEFIBRILLATOR PROGRAM

AUTOMATED EXTERNAL DEFIBRILLATOR GRANT PROGRAM

143.1(135) Purpose
143.2(135) Definitions
143.3(135) Application process
143.4(135) Early defibrillation program
143.5(135) Review process
143.6(135) Appeals
143.7 to 143.9 Reserved

AUTOMATED EXTERNAL DEFIBRILLATOR MAINTENANCE

143.10(135) Purpose
143.11(135) Definition
143.12(135) AED maintenance
143.13 to 143.15 Reserved

FIRE DEPARTMENT RESPONSE WITH AUTOMATED EXTERNAL DEFIBRILLATOR

143.16(147A) Purpose
143.17(147A) Definitions
143.18(147A) Local fire department AED service registration

CHAPTER 144
EMERGENCY MEDICAL SERVICES—AIR MEDICAL SERVICE PROGRAM AUTHORIZATION

144.1(147A) Definitions
144.2(147A) Authority of emergency medical care provider
144.3(147A) Air ambulance service program—authorization and renewal procedures, inspections and transfer or assignment of certificates of authorization
144.4(147A) Service program levels of care and staffing standards
144.5(147A) Air ambulance service program—off-line medical direction
144.6(147A) Complaints and investigations—denial, citation and warning, probation, suspension or revocation of service program authorization or renewal
144.7(147A) Temporary variances
144.8(147A) Transport options for air medical services

CHAPTER 145
IOWA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT

145.1(144D) Definitions
145.2(144D) Purpose
145.3(144D) Responsibilities of the department

CHAPTERS 146 to 149
Reserved

CHAPTER 150
IOWA REGIONALIZED SYSTEM OF PERINATAL HEALTH CARE

150.1(135,77GA,ch1221) Purpose and scope
150.2(135,77GA,ch1221) Definitions
150.3(135,77GA,ch1221) Perinatal guidelines advisory committee
150.4(135,77GA,ch1221) Categorization and selection of level of care designation
150.5(135,77GA,ch1221) Recommendation by the statewide perinatal care program
150.6(135,77GA,ch1221) Level I hospitals
150.7(135,77GA,ch1221) Level II hospitals
150.8(135,77GA,ch1221) Level II regional centers
150.9(135,77GA,ch1221) Level II regional neonatology centers
150.10(135,77GA,ch1221) Level III centers
150.11(135,77GA,ch1221) Grant or denial of certificate of verification; and offenses and penalties
150.12(135,77GA,ch1221) Prohibited acts
150.13(135,77GA,ch1221) Construction of rules

CHAPTER 151
TOBACCO USE PREVENTION AND CONTROL
COMMUNITY PARTNERSHIP INITIATIVE

151.1(142A) Scope
151.2(142A) Community partnership areas
151.3(142A) Community partnerships
151.4(142A) Application requirements for community partnerships
151.5(142A) Performance indicators
151.6(142A) Application deadline
151.7(142A) Distribution of funding
151.8(142A) Gifts

CHAPTER 152
TOBACCO USE PREVENTION AND CONTROL FUNDING PROCESS

152.1(78GA,HF2565) Scope and purpose
152.2(78GA,HF2565) Funding
152.3(78GA,HF2565) Appeals

CHAPTER 153
SMOKEFREE AIR

153.1(82GA,HF2212) Purpose and scope
153.2(82GA,HF2212) Definitions
153.3(82GA,HF2212) Prohibition of smoking
153.4(82GA,HF2212) Areas where smoking not regulated
153.5(82GA,HF2212) Duties of employers, owners, operators, managers, and persons having custody or control of a public place, place of employment, area declared nonsmoking pursuant to 2008 Iowa Acts, House File 2212, section 5, or outdoor areas where smoking is prohibited
153.6(82GA,HF2212) Duties of other state agencies and political subdivisions
153.7(82GA,HF2212) Leases
153.8(82GA,HF2212) Complaints and enforcement
153.9(82GA,HF2212) Limitation of rules

CHAPTER 154
MEDICAL CANNABIDIOL ACT REGISTRATION CARD PROGRAM

154.1(87GA,HF524) Definitions
154.2(87GA,HF524) Health care practitioner certification—duties
154.3(87GA,HF524) Medical cannabidiol registration card—application and issuance to patient
154.4(87GA,HF524) Medical cannabidiol registration card—application and issuance to primary caregiver
154.5(87GA,HF524) Tamperproofing
154.6(87GA,HF524) Denial and cancellation
154.7(87GA,HF524) Appeal
154.8(87GA,HF524) Duplicate card
154.9(87GA,HF524) Renewal
154.10(87GA,HF524) Confidentiality
154.11(87GA,HF524) Agreement with department of transportation
154.12(87GA,HF524) Fees
154.13(87GA,HF524) Use of medical cannabidiol—smoking prohibited
154.14(87GA,HF524) Form and quantity of medical cannabidiol

CHAPTER 155
LICENSURE STANDARDS FOR SUBSTANCE USE DISORDER AND PROBLEM GAMBLING TREATMENT PROGRAMS

155.1(125,135) Definitions
155.2(125,135) Licensing
155.3(125,135) Types of licenses
155.4(125,135) Nonassignability
155.5(125,135) Application procedures
155.6(125,135) Technical assistance
155.7(125,135) Inspection of applicants
155.8(125,135) License—approval
155.9(125,135) Written corrective action plan
155.10(125,135) Grounds for denial of license
155.11(125,135) Denial, suspension or revocation of a license
155.12(125,135) Contested case hearing
155.13(125,135) Rehearing application
155.14(125,135) Judicial review
155.15(125,135) Issuance of a license after denial, suspension or revocation
155.16(125,135) Complaints and investigations
155.17(125,135) License revision
155.18(125,135) Deemed status
155.19(125,135) Funding
155.20(125,135) Inspection
155.21(125,135) General standards for all programs
155.22(125,135) Inpatient and residential program facilities
155.23(125,135) Specific standards for inpatient and residential programs
155.24(125,135) Specific standards for inpatient and residential programs licensed to provide services to juveniles
155.25(125,135) Specific standards for substance use assessment and OWI evaluation-only programs
155.26 to 155.33 Reserved
155.34(125,135) Specific standards for enhanced treatment services
155.35(125,135) Specific standards for opioid treatment programs
155.36(125,135) Purpose

155.37(125,135) Definitions
155.38(125,135) Tuberculosis screening of staff and residents

CHAPTER 156
LICENSURE STANDARDS FOR SUBSTANCE ABUSE TREATMENT PROGRAMS IN CORRECTIONAL FACILITIES

156.1(125) Definitions
156.2(125) Inspection
156.3(125) General standards for all correctional substance abuse treatment programs

CHAPTER 157
STANDARDS FOR SUBSTANCE ABUSE TREATMENT AND ASSESSMENT PROGRAMS AND THE OPERATING A MOTOR VEHICLE WHILE INTOXICATED (OWI) LAW

157.1(125) Definitions
157.2(125) Screening, evaluation, treatment, and drinking drivers course
157.3(125) Screening, evaluation, treatment, and drinking drivers course completion
157.4(125) Cost of evaluation and treatment
157.5(125) Timeliness
157.6(125) Confidentiality
157.7(125) Records
157.8(125) Reciprocity

CHAPTER 158
REGIONS FOR SUBSTANCE ABUSE PREVENTION AND TREATMENT

158.1(125) Service areas established
158.2(125) Request for a change in service areas
158.3(125) Application
158.4(125) Notification of affected parties
158.5(125) Public hearing
158.6(125) Proposed decision
158.7(125) Change during term of contract
158.8(125) State board of health review
158.9(125) State board of health decision

CHAPTERS 159 to 169
Reserved

CHAPTER 170
ORGANIZATION OF THE DEPARTMENT

170.1(17A,135) Definitions
170.2(17A,135) Mission
170.3(17A,136) State board of health
170.4(17A,135) Director of the department of public health
170.5(17A,135) Deputy director
170.6(17A,135) Executive team
170.7(17A,135) Administrative divisions of the department
170.8(17A) Central office
170.9(17A) Business hours
170.10(17A) Submission of materials
170.11(17A) Requests for information

CHAPTER 171
PETITIONS FOR RULE MAKING

171.1(17A) Petition for rule making
171.2(17A) Briefs
171.3(17A) Inquiries
171.4(17A) Department consideration

CHAPTER 172
DECLARATORY ORDERS

172.1(17A) Petition for declaratory order
172.2(17A) Notice of petition
172.3(17A) Intervention
172.4(17A) Briefs
172.5(17A) Inquiries
172.6(17A) Service and filing of petitions and other papers
172.7(17A) Consideration
172.8(17A) Action on petition
172.9(17A) Refusal to issue order
172.10(17A) Contents of declaratory order—effective date
172.11(17A) Copies of orders
172.12(17A) Effect of a declaratory order

CHAPTER 173
CONTESTED CASES

173.1(17A) Scope and applicability
173.2(17A) Definitions
173.3(17A) Time requirements
173.4(17A) Requests for contested case proceeding
173.5(17A) Notice of hearing
173.6(17A) Presiding officer
173.7(17A) Waiver of procedures
173.8(17A) Telephone proceedings
173.9(17A) Disqualification
173.10(17A) Consolidation—severance
173.11(17A) Pleadings
173.12(17A) Service and filing of pleadings and other papers
173.13(17A) Discovery
173.14(17A,135) Subpoenas
173.15(17A) Motions
173.16(17A) Prehearing conference
173.17(17A) Continuances
173.18(17A) Withdrawals
173.19(17A) Intervention
173.20(17A) Hearing procedures
173.21(17A) Evidence
173.22(17A) Default
173.23(17A) Ex parte communication
173.24(17A) Recording costs
173.25(17A) Interlocutory appeals
173.26(17A) Final decision
173.27(17A) Appeals and review
173.28(17A) Applications for rehearing

173.29(17A) Stays of department actions
173.30(17A) No factual dispute contested cases
173.31(17A) Emergency adjudicative proceedings

CHAPTER 174
AGENCY PROCEDURE FOR RULE MAKING
(Uniform Rules)

174.3(17A) Public rule-making docket
174.4(17A) Notice of proposed rule making
174.5(17A) Public participation
174.6(17A) Regulatory flexibility analysis
174.11(17A) Concise statement of reasons
174.13(17A) Agency rule-making record

CHAPTER 175
FAIR INFORMATION PRACTICES AND PUBLIC RECORDS

175.1(17A,22) Definitions
175.2(17A,22) Statement of policy
175.3(17A,22) Requests for access to records
175.4(17A,22) Access to confidential records
175.5(17A,22) Requests for treatment of a record as a confidential record and its withholding from examination
175.6(17A,22) Procedure by which additions, dissents, or objections may be entered into certain records
175.7(17A,22) Consent to disclosure by the subject of a confidential record
175.8(17A,22) Notice to suppliers of information
175.9(17A,22) Disclosures without the consent of the subject
175.10(17A,22) Routine use
175.11(17A,22) Consensual disclosure of confidential records
175.12(17A,22) Release to subject
175.13(17A,22) Availability of records
175.14(17A,22) Personally identifiable information
175.15(17A,22) Other groups of records
175.16(17A,22) Data processing systems
175.17(17A,22) Applicability

CHAPTER 176
CRITERIA FOR AWARDS OR GRANTS

176.1(135,17A) Purpose
176.2(135,17A) Definitions
176.3(135,17A) Exceptions
176.4(135,17A) Requirements
176.5(135,17A) Review process (competitive applications only)
176.6 Reserved
176.7(135,17A) Public notice of available funds
176.8(135,17A) Appeals

CHAPTER 177
HEALTH DATA

177.1(76GA,ch1212) Purpose
177.2(76GA,ch1212) Definitions
177.3(76GA,ch1212) Description of data to be submitted
177.4(76GA,ch1212) Department studies

177.5(76GA,ch1212) Fees
177.6(76GA,ch1212) Patient confidentiality
177.7 Reserved
177.8(76GA,ch1212) Address and specification for data submissions

CHAPTER 178
VARIANCES AND WAIVERS OF PUBLIC HEALTH
ADMINISTRATIVE RULES

178.1(17A,135) Waivers
178.2(17A,135) Sample petition for waiver

CHAPTER 179
COLLECTION OF DELINQUENT DEBTS

179.1(8A) Authorization
179.2(8A) Definitions
179.3(8A) Liability file
179.4(8A) Notification of offset
179.5(8A) Request to divide a jointly or commonly owned right to payment
179.6(8A) Appeal process
179.7(8A) Notice of offset

CHAPTERS 180 to 185
Reserved

CHAPTER 186
GOVERNMENTAL PUBLIC HEALTH ADVISORY COUNCIL

186.1(135A) Purpose
186.2(135A) Definitions
186.3(135A) Roles and responsibilities of the council
186.4(135A) Officers
186.5(135A) Members of the council
186.6(135A) Meetings
186.7(135A) Conflict of interest
186.8(135A) Subcommittees
186.9(135A) Roles and responsibilities of the department

CHAPTERS 187 to 190
Reserved

CHAPTER 191
ADVISORY BODIES OF THE DEPARTMENT

191.1(135) Definitions
191.2(135) Purpose
191.3(135) Appointment
191.4(135) Officers
191.5(135) Meetings
191.6(135) Subcommittees
191.7(135) Expenses of advisory body members
191.8(135) Gender balance

CHAPTER 192
CHILD SUPPORT NONCOMPLIANCE

192.1(252J) Definitions
192.2(252J) Issuance or renewal of a license—denial

192.3(252J) Suspension or revocation of a license
192.4(17A,22,252J) Sharing of information

CHAPTER 193
IMPAIRED PRACTITIONER REVIEW COMMITTEE

193.1(272C) Definitions
193.2(272C) Purpose
193.3(272C) Composition of the committee
193.4(272C) Eligibility
193.5(272C) Terms of participation in the impaired practitioner recovery program
193.6(272C) Limitations
193.7(272C) Confidentiality

CHAPTER 194
NONPAYMENT OF STATE DEBT

194.1(272D) Definitions
194.2(272D) Issuance or renewal of a license—denial
194.3(272D) Suspension or revocation of a license
194.4(272D) Sharing of information

CHAPTER 195
STUDENT LOAN DEFAULT/NONCOMPLIANCE WITH AGREEMENT
FOR PAYMENT OF OBLIGATION

195.1(261) General definitions
195.2(261) Issuance or renewal of a license—denial
195.3(261) Suspension or revocation of a license
195.4(17A,22,261) Sharing of information

CHAPTER 196
MILITARY SERVICE AND VETERAN RECIPROCITY

196.1(85GA,ch1116) Definitions
196.2(85GA,ch1116) Military education, training, and service credit
196.3(85GA,ch1116) Veteran reciprocity

CHAPTERS 197 to 200
Reserved

CHAPTER 201
ORGANIZED DELIVERY SYSTEMS

LICENSURE AND REGULATION

201.1(135,75GA,ch158) Purpose and scope
201.2(135,75GA,ch158) Definitions
201.3(135,75GA,ch158) Application
201.4(135,75GA,ch158) Governing body
201.5(135,75GA,ch158) Service area/geographic access
201.6(135,75GA,ch158,78GA,ch41) Provider network and contracts; treatment and services
201.7(135,75GA,ch158) Complaints
201.8(135,75GA,ch158) Accountability
201.9(135,75GA,ch158) Reporting
201.10(135,75GA,ch158) Evaluation
201.11(135,75GA,ch158) Annual report
201.12(135,75GA,ch158) Finance and solvency
201.13(135,75GA,ch158) Investment

201.14(135,75GA,ch158) Rating practices
201.15(135,75GA,ch158) Name
201.16(135,75GA,ch158) Change in organizational documents or control
201.17(135,75GA,ch158) Appeal
201.18(135,78GA,ch41) External review
201.19 Reserved

ANTITRUST

201.20(135,75GA,ch158) Purpose
201.21(135,75GA,ch158) Definitions
201.22(135,75GA,ch158) Scope
201.23(135,75GA,ch158) Application
201.24(135,75GA,ch158) Notice and comment
201.25(135,75GA,ch158) Procedure for review of applications
201.26(135,75GA,ch158) Criteria for decision
201.27(135,75GA,ch158) Decision
201.28(135,75GA,ch158) Appeal
201.29(135,75GA,ch158) Supervision after approval
201.30(135,75GA,ch158) Revocation

CHAPTER 202
CERTIFICATE OF NEED PROGRAM

202.1(135) Definitions
202.2(135) Letter of intent
202.3(135) Determination of reviewability
202.4(135) Submission of application
202.5(135) Organizational procedures
202.6(135) Public hearing on application
202.7(135) Summary review
202.8(135) Extension of review time
202.9(135) Rehearing of certificate of need decision
202.10(135) Status reports to affected persons
202.11(135) Finality
202.12(135) Project progress reports
202.13(135) Request for extension of certificate
202.14(135) Application changes after approval
202.15(135) Sanctions
202.16(135) Reporting requirements

CHAPTER 203
STANDARDS FOR CERTIFICATE OF NEED REVIEW

203.1 Reserved
203.2(135) Cardiac catheterization and cardiovascular surgery standards
203.3(135) Radiation therapy or radiotherapy standards
203.4(135) Computerized tomography standards
203.5(135) Long-term care
203.6 and 203.7 Reserved
203.8(135) Financial and economic feasibility
203.9 to 203.11 Reserved
203.12(135) Magnetic resonance imaging services standards
203.13(135) Positron emission tomography services standards

CHAPTERS 204 and 205
Reserved

CHAPTER 206
IOWA HEALTH INFORMATION NETWORK

206.1(135) Scope and applicability
206.2(135) Definitions
206.3(135) Policy development and governance
206.4(135) Monitoring and audit
206.5(135) Consumer participation in the Iowa health information network
206.6(135) Security incidents, breaches
206.7(135) Health information audit

CHAPTER 154
MEDICAL CANNABIDIOL ACT REGISTRATION CARD PROGRAM

641—154.1(87GA,HF524) Definitions. For the purposes of these rules, the following definitions shall apply:

"Bordering state" means the same as defined in Iowa Code section 331.910.

"Date of expiration" means one year from the date of issuance of the medical cannabidiol registration card by the department of transportation.

"Date of issuance" means the date of issuance of the medical cannabidiol registration card by the department of transportation.

"Debilitating medical condition" means any of the following:

1. Cancer, if the underlying condition or treatment produces one or more of the following:
- Severe or chronic pain.
- Nausea or severe vomiting.
- Cachexia or severe wasting.
2. Multiple sclerosis with severe and persistent muscle spasms.
3. Seizures, including those characteristic of epilepsy.
4. AIDS or HIV as defined in Iowa Code section 141A.1.
5. Crohn's disease.
6. Amyotrophic lateral sclerosis.
7. Any terminal illness, with a probable life expectancy of under one year, if the illness or its treatment produces one or more of the following:
- Severe or chronic pain.
- Nausea or severe vomiting.
- Cachexia or severe wasting.
8. Parkinson's disease.
9. Untreatable pain.

"Department" means the Iowa department of public health.

"Department of transportation" means the Iowa department of transportation.

"Disqualifying felony offense" means a violation under federal or state law of a felony under federal or state law, which has as an element the possession, use, or distribution of a controlled substance, as defined in 21 U.S.C. §802(6).

"Health care practitioner" means an individual licensed under Iowa Code chapter 148 to practice medicine and surgery or osteopathic medicine and surgery who is a patient's primary care provider. "Health care practitioner" shall not include a physician assistant licensed under Iowa Code chapter 148C or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 or 152E.

"Medical assistance program" means IA Health Link, Medicaid Fee-for-Service, or HAWK-I, as administered by the Iowa Medicaid enterprise of the Iowa department of human services.

"Medical cannabidiol" means any pharmaceutical grade cannabinoid found in the plant *Cannabis sativa* L. or *Cannabis indica* or any other preparation thereof that has a tetrahydrocannabinol level of no more than 3 percent and that is delivered in a form recommended by the medical cannabidiol board, approved by the board of medicine, and designated in this chapter.

"Patient" means a person who is a permanent resident of the state of Iowa who suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol pursuant to 2017 Iowa Acts, House File 524.

"Permanent resident" means a natural person who physically resides in Iowa as the person's principal and primary residence and who establishes evidence of such residency by providing the department with one of the following:

1. A valid Iowa driver's license,
2. A valid Iowa nonoperator's identification card,
3. A valid Iowa voter registration card,
4. A current Iowa vehicle registration certificate,

5. A utility bill,
6. A statement from a financial institution,
7. A residential lease agreement,
8. A check or pay stub from an employer,
9. A child's school or child care enrollment documents,
10. Valid documentation establishing a filing for homestead or military tax exemption on property located in Iowa, or
11. Other valid documentation as deemed acceptable by the department to establish residency.

"Primary caregiver" means a person who is a resident of this state or a bordering state, including but not limited to a parent or legal guardian, at least 18 years of age, who has been designated by a patient's health care practitioner as a necessary caretaker taking responsibility for managing the well-being of the patient with respect to the use of medical cannabidiol pursuant to the provisions of 2017 Iowa Acts, House File 524.

"Primary care provider" means any health care practitioner involved in the diagnosis and treatment of a patient's debilitating medical condition.

"State" means a state of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands.

"Untreatable pain" means any pain whose cause cannot be removed and, according to generally accepted medical practice, the full range of pain management modalities appropriate for the patient has been used without adequate result or with intolerable side effects.

"Written certification" means a document signed by a health care practitioner, with whom the patient has established a patient-provider relationship, which states that the patient has a debilitating medical condition and identifies that condition and provides any other relevant information.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.2(87GA,HF524) Health care practitioner certification—duties.

154.2(1) Prior to a patient's submission of an application for a medical cannabidiol registration card pursuant to this rule, a health care practitioner shall do all of the following:

a. Determine, in the health care practitioner's medical judgment, whether the patient whom the health care practitioner has examined and treated suffers from a debilitating medical condition that qualifies for the use of medical cannabidiol as defined by this chapter, and if so determined, provide the patient with a written certification of that diagnosis by completing the health care practitioner section of the application form provided for this purpose on the department's Web site (www.idph.iowa.gov).

b. Provide explanatory information to the patient as provided on the department's Web site (www.idph.iowa.gov) about the therapeutic use of medical cannabidiol and the possible risks, benefits, and side effects of the proposed treatment.

154.2(2) Subsequently, the health care practitioner shall do the following:

a. Determine, on an annual basis, if the patient continues to suffer from a debilitating medical condition and, if so, issue the patient a new certification of that diagnosis.

b. Otherwise comply with all requirements in this chapter and requests from the department for more information.

154.2(3) A health care practitioner may provide, but has no duty to provide, a written certification pursuant to this rule.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.3(87GA,HF524) Medical cannabidiol registration card—application and issuance to patient.

154.3(1) Subject to subrule 154.3(7), the department may approve the issuance of a medical cannabidiol registration card by the department of transportation to a patient who:

a. Is at least 18 years of age.

b. Is a permanent resident of Iowa.

c. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(87GA,HF524) and signed by the patient's health care practitioner certifying that the patient is suffering from a debilitating medical condition.

d. Submits an application to the department, on a form created by the department in consultation with the department of transportation and available at the department's Web site (www.idph.iowa.gov), that contains all of the following:

(1) The patient's full legal name, Iowa residence address, mailing address (if different from the patient's residence address), telephone number, date of birth, and sex designation. The patient shall not provide as a mailing address an address for which a forwarding order is in place.

(2) A copy of the patient's valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver's license,

2. A valid Iowa nonoperator's identification card, or

3. An alternative form of valid photo identification. A patient who possesses or is eligible for an Iowa driver's license or an Iowa nonoperator's identification card shall present such document as valid photo identification. A patient who is ineligible to obtain an Iowa driver's license or an Iowa nonoperator's identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A patient who applies for an exemption is subject to verification of the patient's identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(3) Full name, address, and telephone number of the patient's health care practitioner.

(4) Full legal name, residence address, date of birth, and telephone number of each primary caregiver of the patient, if any.

(5) An attestation as to the truthfulness and accuracy of the information provided by the patient on the application.

e. Has not been convicted of a disqualifying felony offense.

f. Submits the required fee, as described in subrule 154.12(1).

154.3(2) Upon the completion, verification, and approval of the patient's application and the receipt of the required fee, the department shall notify the department of transportation that the patient may be issued a medical cannabidiol registration card.

154.3(3) A medical cannabidiol registration card issued to a patient by the department of transportation shall contain all of the following:

a. The patient's full legal name, Iowa residence address, date of birth, and sex designation, as shown on the patient's Iowa driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)*"d"*(2)"3." If the patient's name, Iowa residence address, date of birth, or sex designation has changed since the issuance of the patient's Iowa driver's license, nonoperator's identification card, or alternative form of valid photo identification, the patient shall first update the patient's Iowa driver's license or nonoperator's identification card to reflect the current information, according to the procedures set forth in 761—subrule 605.11(2), 761—subrule 605.25(4), or rule 761—630.3(321), or shall update the alternative form of valid photo identification in accordance with the process of the issuing agency.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the patient's social security number.

d. The patient's signature. The signature shall be without qualification and shall contain only the patient's usual signature without any other titles, characters, or symbols. The patient's signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the patient's application for a medical cannabidiol registration card are true and correct. The patient's signature shall be captured electronically.

e. A color photograph of the patient.

f. A statement that the medical cannabidiol registration card is not valid for identification purposes.

154.3(4) Every patient 18 years of age or older must obtain a valid medical cannabidiol registration card to use medical cannabidiol in Iowa.

154.3(5) An authorization to use medical cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of 2017 Iowa Acts, House File 524, or these rules for the issuance of a medical cannabidiol registration card.

154.3(6) A valid medical cannabidiol registration card, or its equivalent, issued under the laws of another state that allow an out-of-state patient to possess or use medical cannabidiol in the jurisdiction of issuance shall have the same force and effect as a valid medical cannabidiol registration card issued pursuant to 2017 Iowa Acts, House File 524, except that an out-of-state patient in Iowa shall not obtain medical cannabidiol from a medical cannabidiol dispensary in Iowa.

154.3(7) The department shall not approve the issuance of a medical cannabidiol registration card for a patient who is enrolled in a federally approved clinical trial for the treatment of a debilitating medical condition with medical cannabidiol.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.4(87GA,HF524) Medical cannabidiol registration card—application and issuance to primary caregiver.

154.4(1) For a patient in a primary caregiver's care, the department may approve the issuance of a medical cannabidiol registration card by the department of transportation to a primary caregiver who:

a. Is at least 18 years of age.

b. Submits a written certification to the department, provided to the patient pursuant to rule 641—154.2(87GA,HF524) and signed by the patient's health care practitioner certifying that the patient is suffering from a debilitating medical condition.

c. Submits an application as a primary caregiver for each patient for whom the person is the primary caregiver. The primary caregiver application must be on a form created by the department in consultation with the department of transportation and available at the department's Web site (www.idph.iowa.gov) that contains all of the following:

(1) The primary caregiver's full legal name, residence address, mailing address (if different from the primary caregiver's residence address), telephone number, date of birth, and sex designation. The primary caregiver shall not provide as a mailing address an address for which a forwarding order is in place.

(2) The patient's full legal name, date of birth, and parent or legal guardian's name if the patient is under the age of 18.

(3) A copy of the primary caregiver's valid photo identification. Acceptable photo identification includes:

1. A valid Iowa driver's license,

2. A valid Iowa nonoperator's identification card,

3. If the primary caregiver is not a resident of the state of Iowa, a valid state-issued driver's license or nonoperator's identification card issued by a state other than Iowa, or

4. An alternative form of valid photo identification. A primary caregiver who possesses or is eligible for a driver's license or a nonoperator's identification card shall present such document as valid photo identification. A primary caregiver who is ineligible to obtain a driver's license or a nonoperator's identification card may apply for an exemption and request submission of an alternative form of valid photo identification. A primary caregiver who applies for an exemption is subject to verification of the primary caregiver's identity through a process established by the department and the department of transportation to ensure the genuineness, regularity, and legality of the alternative form of valid photo identification.

(4) Full name, address, and telephone number of the patient's health care practitioner.

(5) An attestation as to the truthfulness and accuracy of the information provided by the primary caregiver on the application.

d. Has not been convicted of a disqualifying felony offense.

e. Submits the required fee, as described in subrule 154.12(2).

154.4(2) Upon the completion, verification, and approval of the primary caregiver's application, the department shall notify the department of transportation that the primary caregiver may be issued a medical cannabidiol registration card.

154.4(3) A medical cannabidiol registration card issued to a primary caregiver by the department of transportation shall contain all of the following:

a. The primary caregiver's full legal name, current residence address, date of birth, and sex designation, as shown on the primary caregiver's state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.4(1)*"c"*(3)"4." If the primary caregiver's name, current residence address, date of birth, or sex designation has changed since issuance of the primary caregiver's Iowa-issued driver's license, nonoperator's identification card, or other form of valid photo identification, the primary caregiver shall first update the primary caregiver's Iowa-issued driver's license or nonoperator's identification card according to the procedures set forth in 761—subrule 605.11(2), 761—subrule 605.25(4), or rule 761—630.3(321) or update the alternative form of valid photo identification in accordance with the process of the issuing agency.

b. The date of issuance and the date of expiration, which shall be one year from the date of issuance.

c. A distinguishing registration number that is not the primary caregiver's social security number.

d. The medical cannabidiol registration number for each patient in the primary caregiver's care. This number shall not be the primary caregiver's or patient's social security number. If the patient in the primary caregiver's care is under the age of 18, the full name of the patient's parent or legal guardian shall be printed on the primary caregiver's registration card in lieu of the patient's medical cannabidiol registration number.

e. The primary caregiver's signature. The signature shall be without qualification and shall contain only the primary caregiver's usual signature without any other titles, characters, or symbols. The primary caregiver's signature certifies, under penalty of perjury and pursuant to the laws of the state of Iowa, that the statements made and information provided in the primary caregiver's application for a medical cannabidiol registration card are true and correct. The primary caregiver's signature shall be captured electronically.

f. A color photograph of the primary caregiver.

g. A statement that the medical cannabidiol registration card is not valid for identification purposes.

h. A statement distinguishing the medical cannabidiol registration cardholder as a primary caregiver.

154.4(4) A patient who is 18 years of age or older must have an approved application and a distinguishing medical cannabidiol registration number that is not the patient's social security number prior to the issuance of a medical cannabidiol registration card to the patient's primary caregiver.

154.4(5) An authorization to use, or to act as a primary caregiver for a patient authorized to use, cannabidiol or marijuana for medicinal purposes issued by another state, territory, or jurisdiction does not satisfy the requirements of 2017 Iowa Acts, House File 524, or these rules for the issuance of a medical cannabidiol registration card.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.5(87GA,HF524) Tamperproofing. The department of transportation shall issue a medical cannabidiol registration card by a method or process which prevents as nearly as possible the alteration, reproduction, or superimposition of a photograph on the cannabidiol registration card without ready detection.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.6(87GA,HF524) Denial and cancellation. The department may deny an application for a medical cannabidiol registration card, or may cancel or direct the department of transportation to cancel a medical cannabidiol registration card, for any of the following reasons:

1. Information contained in the application is illegible, incomplete, falsified, misleading, deceptive, or untrue.

2. The department or the department of transportation is unable to verify the identity of the applicant from the photo identification or other documentation presented pursuant to paragraph 154.3(1)*"d"*(2)"3" or 154.4(1)*"c"*(3)"4."

3. The applicant violates or fails to satisfy any of the provisions of 2017 Iowa Acts, House File 524, or these rules.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.7(87GA,HF524) Appeal. If the department denies an application for or cancels a medical cannabidiol registration card, the department shall inform the applicant or cardholder of the denial or cancellation and state the reasons for the denial or cancellation in writing. An applicant or cardholder may appeal the denial or cancellation of a medical cannabidiol registration card by submitting a request for appeal to the department by certified mail, return receipt requested, within 20 days of receipt of the notice of denial or cancellation. The department's address is Iowa Department of Public Health, Lucas State Office Building, 321 E. 12th Street, Des Moines, Iowa 50319-0075. Upon receipt of a request for appeal, the department shall forward the request within five working days to the department of inspections and appeals. A contested case hearing shall be conducted in accordance with 641—Chapter 173.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.8(87GA,HF524) Duplicate card.

154.8(1) *Lost, stolen, or destroyed card.* To replace a medical cannabidiol registration card that is lost, stolen, or destroyed, a cardholder shall present to the department of transportation the cardholder's valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)*"d"*(2)"3" or 154.4(1)*"c"*(3)"4."

154.8(2) *Change in card information and voluntary replacement.*

a. To replace a medical cannabidiol registration card that is damaged, the cardholder shall surrender to the department of transportation the card to be replaced and present the cardholder's valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)*"d"*(2)"3" or 154.4(1)*"c"*(3)"4."

b. A patient or primary caregiver to whom a medical cannabidiol registration card is issued shall notify the department of a change in current residence address, name, or sex designation listed on the card, within ten calendar days of the change. To replace a medical cannabidiol registration card to change the current residence address, name, or sex designation listed on the card, the cardholder shall surrender to the department of transportation the card to be replaced and present a valid state-issued driver's license, nonoperator's identification card, or alternative form of valid photo identification provided pursuant to paragraph 154.3(1)*"d"*(2)"3" or 154.4(1)*"c"*(3)"4" that has been updated according to the procedures established by the state or agency of issuance to reflect the requested residence address, name, or sex designation.

c. To replace a medical cannabidiol registration card held by a primary caregiver to change, add, or remove a patient's medical cannabidiol registration number or the name of a patient's parent or legal guardian listed on the primary caregiver's card, the primary caregiver shall submit a new application to the department pursuant to rule 641—154.4(87GA,HF524). A medical cannabidiol registration card issued pursuant to this paragraph shall not be considered a duplicate card.

154.8(3) *Expiration date.* A duplicate medical cannabidiol registration card shall have the same expiration date as the medical cannabidiol registration card being replaced, changed, or amended.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.9(87GA,HF524) Renewal. A medical cannabidiol registration card shall be valid for one year from the date of issuance unless canceled pursuant to rule 641—154.6(87GA,HF524).

154.9(1) A cardholder seeking renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department at least 60 days prior to the date of expiration.

a. A patient applying for renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.

b. A primary caregiver applying for a renewal of a medical cannabidiol registration card shall submit a renewal application and fee to the department on a form approved by the department.

154.9(2) A cardholder who fails to renew the medical cannabidiol registration card may not lawfully possess medical cannabidiol pursuant to this chapter.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.10(87GA,HF524) Confidentiality. The department shall maintain a confidential file of the names of each patient to or for whom the department approves the issuance of a medical cannabidiol registration card and the name of each primary caregiver to whom the department issues a medical cannabidiol registration card under 2017 Iowa Acts, House File 524, section 7.

154.10(1) Personally identifiable information of patients and primary caregivers shall be maintained as confidential and is not accessible to the public. The department and the department of transportation shall release aggregate and statistical information regarding the medical cannabidiol act registration card program in a manner which prevents the identification of any patient or primary caregiver.

154.10(2) Personally identifiable information of patients and primary caregivers may be disclosed under the following limited circumstances:

a. To authorized employees or agents of the department and the department of transportation as necessary to perform the duties of the department and the department of transportation pursuant to 2017 Iowa Acts, House File 524.

b. To authorized employees of state or local law enforcement agencies located in Iowa, solely for the purpose of verifying that a person is lawfully in possession of a medical cannabidiol registration card issued pursuant to 2017 Iowa Acts, House File 524.

c. To a patient, primary caregiver, or health care practitioner, upon written authorization of the patient or primary caregiver.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.11(87GA,HF524) Agreement with department of transportation. The department may enter into a chapter 28E agreement with the department of transportation to facilitate the issuance of medical cannabidiol registration cards. The agreement may include provisions which govern the issuance, denial, and cancellation of medical cannabidiol registration cards, the sharing of information between the department and the department of transportation, and reimbursement for costs incurred by the department of transportation for issuing the card.

[**ARC 1640C**, IAB 10/1/14, effective 1/30/15; **ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.12(87GA,HF524) Fees. All fees are nonrefundable.

154.12(1) *Patient medical cannabidiol registration card fee.*

a. Each application fee is $100 unless the patient qualifies for a reduced fee as described in paragraph 154.12(1)*"b."*

b. Each reduced application fee is $25 if the patient attests to receiving social security disability benefits, supplemental security income payments, or is enrolled in the medical assistance program as defined in rule 641—154.1(87GA,HF524).

c. Each renewal fee is the same as the initial card application fee.

154.12(2) *Primary caregiver medical cannabidiol registration card fee.*

a. Each application fee is $25.

b. Each renewal fee is $25.

[**ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.13(87GA,HF524) Use of medical cannabidiol—smoking prohibited. A patient shall not consume medical cannabidiol possessed or used pursuant to 2017 Iowa Acts, House File 524, by smoking medical cannabidiol.

[**ARC 3150C**, IAB 7/5/17, effective 6/13/17]

641—154.14(87GA,HF524) Form and quantity of medical cannabidiol.

154.14(1) *Patient.* A patient in possession of a valid medical cannabidiol registration card issued pursuant to this chapter shall not possess a quantity of medical cannabidiol in excess of 32 ounces.

154.14(2) *Primary caregiver.* A primary caregiver in possession of a valid medical cannabidiol registration card issued pursuant to this chapter shall not possess a quantity of medical cannabidiol in excess of 32 ounces for each patient for whom the person is registered as a primary caregiver.

154.14(3) *Form and quantity.* The form and quantity of medical cannabidiol authorized in this rule may be modified pursuant to recommendations by the medical cannabidiol board established pursuant to 2017 Iowa Acts, House File 524, and subsequent approval of the recommendations by the board of medicine.

[**ARC 3150C**, IAB 7/5/17, effective 6/13/17]

These rules are intended to implement 2017 Iowa Acts, House File 524.

[Filed ARC 1640C (Notice ARC 1571C, IAB 8/6/14), IAB 10/1/14, effective 1/30/15]

[Filed Emergency ARC 3150C, IAB 7/5/17, effective 6/13/17]

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.

GENERAL

CHAPTER 1
ORGANIZATION OF THE DEPARTMENT OF TRANSPORTATION

1.1(307) Definitions
1.2(17A) Mission
1.3(17A) Location and business hours
1.4(17A) Information and forms
1.5(307) History
1.6(17A,307A) Commission
1.7(17A,307) Director of transportation
1.8(17A,307) Divisions

CHAPTER 2
PROVISIONS APPLICABLE TO ALL RULES

2.1(307) Definitions

CHAPTER 3
Reserved

CHAPTER 4
PUBLIC RECORDS AND FAIR INFORMATION PRACTICES
(Uniform Rules)

4.1(22,305) General provisions
4.2(22) Statement of policy and purpose
4.3(22) Access to records
4.4(22) Access to confidential records
4.5(22) Consent to release a confidential record to a third party
4.6(22) Requests for confidential treatment
4.7(22) Procedure by which additions, dissents, or objections may be entered into records
4.8(22) Notice to suppliers of information
4.9(22) Confidential records

CHAPTERS 5 to 9
Reserved

CHAPTER 10
ADMINISTRATIVE RULES

10.1(17A) General
10.2(17A) Rule making
10.3(17A) Petitions for rule making

CHAPTER 11
WAIVER OF RULES

11.1(17A) Purpose and scope
11.2(17A) Authority to grant waiver
11.3(17A) Criteria, considerations and limitations
11.4(17A) Decision on waiver
11.5(17A) Petition for waiver
11.6(17A) Action on petition
11.7(17A) Modification or cancellation of waiver
11.8(17A) Records

CHAPTER 12
DECLARATORY ORDERS

12.1(17A)	Definitions
12.2(17A)	Petition for declaratory order
12.3(17A)	Notice of petition
12.4(17A)	Action on petition
12.5(17A)	Effect of a declaratory order

CHAPTER 13
CONTESTED CASES

13.1(17A)	Definitions
13.2(17A)	Applicability
13.3(17A)	Initiation of contested case
13.4(17A)	Submission of request for informal settlement or hearing
13.5(17A)	Informal settlement
13.6(17A)	Contested case decision
13.7(17A)	Appeal
13.8(17A)	Motion for review
13.9(17A)	Rehearings
13.10(17A)	Maintenance of records
13.11(17A)	Use of legal assistants or paralegals
13.12(17A)	Communications
13.13(17A)	Default
13.14 to 13.19	Reserved
13.20(17A)	Additional procedures when the department is not a party

CHAPTERS 14 to 19
Reserved

CHAPTER 20
PROCUREMENT OF EQUIPMENT, MATERIALS, SUPPLIES AND SERVICES

20.1(307)	Scope of chapter
20.2(307)	Definitions
20.3(307)	Procurement policy
20.4(307)	Formal advertising procedures and requirements
20.5(307)	Limited solicitation of bids
20.6 and 20.7	Reserved
20.8(307)	Negotiation—architectural, landscape architectural, engineering and related professional and technical services

CHAPTERS 21 to 24
Reserved

CHAPTER 25
COMPETITION WITH PRIVATE ENTERPRISE

25.1(23A)	Interpretation
25.2(23A)	Exemptions

CHAPTER 26
Reserved

CHAPTER 27
INTEREST ON RETAINED FUNDS

27.1(573) Interest on retained funds

CHAPTER 28
IOWA TRANSPORTATION MAP

28.1(307) Definition
28.2(307) Information
28.3(307) Policy

CHAPTERS 29 to 39
Reserved

CHAPTER 40
RECOVERY OF DAMAGES TO HIGHWAYS OR HIGHWAY STRUCTURES

40.1(321) Scope
40.2(321) Definitions
40.3(321) Information
40.4(321) Accident scene
40.5(321) Repair of facilities
40.6(321) Recovery of damages

CHAPTERS 41 to 99
Reserved

HIGHWAYS

CHAPTER 100
Reserved

CHAPTER 101
FARM-TO-MARKET REVIEW BOARD

101.1(306) Purpose
101.2(306) Definitions
101.3(306) Composition and membership of the farm-to-market review board
101.4(306) Collection of system modification requests and frequency of meetings
101.5(306) Procedure for requesting modifications to the farm-to-market road system
101.6(306) Review criteria for determining eligibility for inclusion of additional roads into the farm-to-market road system
101.7(306) Voting and approval of requested modifications
101.8(306) Report of board decision to applicant county
101.9(306) Reapplication for modification
101.10(306) Judicial review
101.11(306) Adoption and modification of rules
101.12(306) Severability clause

CHAPTER 102
SECONDARY ROAD FUND DISTRIBUTION COMMITTEE

102.1(312) Purpose
102.2(312) Formulas
102.3 and 102.4 Reserved
102.5(312) Composition and membership of the secondary road fund distribution committee
102.6(312) Terms of office and rotation of seats
102.7(312) Committee meetings
102.8 and 102.9 Reserved

102.10(312) Considerations for a new or modified distribution formula
102.11(312) Process for approval of a new or modified distribution formula
102.12(312) Judicial review
102.13(312) Severability clause

CHAPTERS 103 and 104
Reserved

CHAPTER 105
HOLIDAY REST STOPS
105.1(307) Purpose
105.2(307) General
105.3(321) Conditions
105.4(321) Holiday rest stops on interstate highways
105.5(307) Holiday rest stops on primary highways

CHAPTER 106
PROMOTION OF IOWA AGRICULTURAL PRODUCTS AT REST AREAS
106.1(307) Purpose
106.2(307) Definitions
106.3(307) Information
106.4(307) Request
106.5(307) Time frame
106.6(307) Conditions
106.7(307) Site location

CHAPTERS 107 to 109
Reserved

RIGHT-OF-WAY AND ENVIRONMENT

CHAPTER 110
HIGHWAY PROJECT PLANNING
110.1(17A) Availability of information

CHAPTER 111
REAL PROPERTY ACQUISITION AND RELOCATION ASSISTANCE
111.1(316) Acquisition and relocation assistance manual

CHAPTER 112
PRIMARY ROAD ACCESS CONTROL
112.1(306A) General information
112.2(306A) Definitions
112.3(306A) General requirements for control of access
112.4(306A) General requirements for entrances where access rights have not been acquired
112.5(306A) Additional requirements for Type “A” entrances
112.6(306A) Drainage requirements
112.7(306A) Access to Priority I, II, III and IV highways
112.8(306A) Access to Priority V highways, rural areas
112.9(306A) Access to Priority V highways, fringe or built-up areas, and Priority VI highways, all areas
112.10 Reserved
112.11(306A) Policy on acquisition of access rights
112.12(306A) Policy on location of predetermined access locations

112.13(306A) Policy on special access connections where access rights have been previously acquired
112.14(306A) Recreational trail connections

CHAPTERS 113 and 114
Reserved

CHAPTER 115
UTILITY ACCOMMODATION

115.1(306A) General information
115.2(306A) Definitions
115.3 Reserved
115.4(306A) General requirements for occupancy of the right-of-way
115.5(306A) General design provisions
115.6(306A) Scenic enhancement
115.7(306A) Liability
115.8(306A) Utility accommodation permit
115.9(306A) Traffic protection
115.10(306A) Construction responsibilities and procedures
115.11(306A) Vertical overhead clearance requirements
115.12(306A) Utility facility attachments to bridges
115.13(306A) Underground utility facilities
115.14(306A) Freeways
115.15(306A) Transverse installations on freeways
115.16(306A) Longitudinal installations on freeways
115.17(306A) Nonfreeway primary highways
115.18(306A) Longitudinal installations on nonfreeway primary highways
115.19(306A) Maintenance and emergency work
115.20(306A) Abandonment or removal of utility facilities
115.21 to 115.24 Reserved
115.25(306A) Utility facility adjustments for highway improvement projects
115.26(306A) Notice of project
115.27(306A) First plan submission, preliminary work plan and agreement
115.28(306A) Second plan submission, final work plan and permit application
115.29(306A) Notice of work
115.30(306A) Miscellaneous adjustment provisions

CHAPTER 116
JUNKYARD CONTROL

116.1(306C) Definitions
116.2(306C) Junkyards prohibited—exceptions
116.3(306C) Screening or removal
116.4(306C) Acquisition
116.5(306C) Screening
116.6(306C) Nuisance—injunction
116.7(17A) Hearings and appeals
116.8(306C) Contact information

CHAPTER 117
OUTDOOR ADVERTISING

117.1(306B,306C) Definitions
117.2(306B,306C) General provisions
117.3(306B,306C) General criteria

117.4(306B,306C) Interstate special provisions for on-premises signs
117.5(306B,306C) Location, size and spacing requirements
117.6(306C) Outdoor advertising permits and fees required
117.7(306C) Official signs and notices, public utility signs, and service club and religious notices
117.8(306B,306C) Removal procedures
117.9(306B,306C) Acquisition of advertising devices that have been issued provisional permits
117.10(17A,306C) Contested cases
117.11 to 117.14 Reserved
117.15(306C) Development directory signing

CHAPTER 118
LOGO SIGNING

118.1(306C) Introduction
118.2(306C) Definitions
118.3(306C) Erection and location of specific service signs and placement of business signs
118.4(306C) Eligibility for placement of business signs on mainline specific service signs
118.5(306C) Application, drawing, and fees
118.6(306C) Business sign blank specifications
118.7(306C) Business sign face specifications

CHAPTER 119
TOURIST-ORIENTED DIRECTIONAL SIGNING

119.1(321) Definitions
119.2(321) General
119.3(321) General eligibility requirements for an activity or site
119.4(321) Specific eligibility requirements for the type of activity or site
119.5(321) Application and approval procedure
119.6(321) Installation, maintenance, replacement and removal

CHAPTER 120
PRIVATE DIRECTIONAL SIGNING

120.1(306C) Definitions
120.2(306C,657) General requirements
120.3(306C) Size requirements
120.4(306C) Lighting requirements
120.5(306C) Spacing and location requirements
120.6(306C) Message content
120.7(306C) Eligibility for private directional signs
120.8(306C) Application and approval procedures
120.9(306C) Fees
120.10(306C) Erection and maintenance

CHAPTER 121
ADOPT-A-HIGHWAY PROGRAM

121.1(307) Purpose
121.2(307) Information and location
121.3(307) Program guidelines
121.4(307) Sponsors
121.5(307) Eligible activities
121.6(307) Procedure

CHAPTER 122
Reserved

CHAPTER 123
REST AREA SPONSORSHIP PROGRAM

123.1(307)	Introduction and purpose
123.2(307)	Contact information
123.3(307)	Definitions
123.4(307)	General provisions
123.5(307)	Sponsorship agreements
123.6(307)	Acknowledgment sign criteria

CHAPTER 124
HIGHWAY HELPER SPONSORSHIP PROGRAM

124.1(307)	Introduction and purpose
124.2(307)	Contact information
124.3(307)	Definitions
124.4(307)	General provisions
124.5(307)	Sponsorship agreements
124.6(307)	Acknowledgment sign criteria

CONSTRUCTION

CHAPTER 125
GENERAL REQUIREMENTS AND COVENANTS FOR HIGHWAY AND BRIDGE CONSTRUCTION

125.1(307A)	Standard specifications
125.2	Reserved
125.3(307A)	Availability of specifications

CHAPTERS 126 to 129
Reserved

TRAFFIC OPERATIONS

CHAPTER 130
SIGNING MANUAL

130.1(321)	Manual

CHAPTER 131
SIGNING ON PRIMARY HIGHWAYS

131.1(321)	Destination signs at an intersection
131.2(321)	Erection of signs for numbered business routes
131.3(321)	Erection of signs for schools
131.4(321)	Erection of camping service signs on interstate highways
131.5(321)	Erection of signs for sanitary landfills
131.6(321)	Erection of signs for special events
131.7(321)	Erection of signs for organized off-highway camps
131.8(321)	Erection of signs for county conservation parks
131.9(321)	Erection of no parking signs
131.10(321)	Signing for named routes and memorial bridges
131.11 to 131.14	Reserved
131.15(321)	Information and address

CHAPTER 132
IOWA SCENIC BYWAY PROGRAM

132.1(306D)	Purpose, overview and information
132.2(306D)	Definition

132.3(306D) Designations
132.4(306D) General requirements
132.5(306D) Application and approval process
132.6(306D) Reevaluation
132.7(306D) Promotional and tourism efforts

CHAPTERS 133 to 135
Reserved

CHAPTER 136
LIGHTING
136.1(319) Lighting of primary-secondary intersections
136.2(319) Destination lighting
136.3 to 136.5 Reserved
136.6(306) Warrants and design requirements for lighting

CHAPTERS 137 to 139
Reserved

CHAPTER 140
TRAFFIC SIGNALS AND BEACONS
ON PRIMARY ROADS
140.1(321) Erection of traffic signals and beacons on primary highways

CHAPTER 141
Reserved

CHAPTER 142
SPEED ZONING ON PRIMARY HIGHWAYS
142.1(321) Adjustment of speed zones on primary highways

CHAPTER 143
TRAFFIC SIGNAL SYNCHRONIZATION
143.1(364) Definitions
143.2(364) Applicability
143.3 Reserved
143.4(364) Required synchronization

CHAPTER 144
AUTOMATED TRAFFIC ENFORCEMENT ON THE PRIMARY ROAD SYSTEM
144.1(307) Purpose
144.2(307) Contact information
144.3(307) Definitions
144.4(307) Overview
144.5(307) Automated traffic enforcement system request
144.6(306,307,318,321) Minimum requirements for automated traffic enforcement systems
144.7(307) Evaluation and reporting
144.8(307) Continued use of automated traffic enforcement system
144.9(307) Appeal process

CHAPTERS 145 to 149
Reserved

PRIMARY ROAD EXTENSIONS

CHAPTER 150
IMPROVEMENTS AND MAINTENANCE ON PRIMARY ROAD EXTENSIONS

150.1(306) Definitions
150.2(306) Improvements and maintenance on extensions of freeways
150.3(306) Improvements and maintenance on extensions of nonfreeway primary highways
150.4(306) General requirements for primary road extensions

CHAPTER 151
CITY REQUESTS FOR CLOSURE OF
PRIMARY ROAD EXTENSIONS

151.1(321) Closing primary road extensions

CHAPTERS 152 to 159
Reserved

SPECIAL HIGHWAY PROGRAMS

CHAPTER 160
COUNTY AND CITY BRIDGE CONSTRUCTION FUNDS

160.1(312) Purpose
160.2(312) Contact information
160.3(312) Source of funds
160.4(312) Administration of funds

CHAPTER 161
FEDERAL-AID HIGHWAY BRIDGE PROGRAM

161.1(307) Purpose
161.2(307) Contact information
161.3(307) Source of funds
161.4(307) Administration of funds

CHAPTER 162
SURFACE TRANSPORTATION BLOCK GRANT PROGRAM

162.1(86GA,SF2320) Purpose
162.2(86GA,SF2320) Contact information
162.3(86GA,SF2320) Source of funds
162.4(86GA,SF2320) Administration of funds

CHAPTER 163
RISE PROGRAM

163.1(315) Definitions
163.2(315) Purpose of RISE program
163.3(315) Administration of RISE program
163.4(315) Source, allocation, and use of RISE funds
163.5(315) Project financing and funding shares
163.6(315) Eligibility of applicants and joint applications
163.7(315) Project activities eligible and ineligible for RISE funds
163.8(315) Immediate opportunity projects
163.9(315) Local development projects
163.10 Reserved
163.11(315) Project administration

CHAPTER 164
TRAFFIC SAFETY IMPROVEMENT PROGRAM

164.1(312)	Definitions
164.2(312)	Information and forms
164.3(312)	Program administration
164.4(312)	Applicant eligibility
164.5(312)	Project eligibility
164.6(312)	Eligible project costs
164.7(312)	Ineligible project costs
164.8(312)	Applications
164.9(312)	Processing the application
164.10(312)	Project agreement

CHAPTER 165
RECREATIONAL TRAILS PROGRAM

165.1(312)	Definitions
165.2(312)	Information and forms
165.3 and 165.4	Reserved
165.5(312)	Program administration
165.6 to 165.8	Reserved
165.9(312)	Applicant eligibility
165.10 and 165.11	Reserved
165.12(312)	Project eligibility
165.13 and 165.14	Reserved
165.15(312)	Eligible project costs
165.16	Reserved
165.17(312)	Ineligible project costs
165.18	Reserved
165.19(312)	Advance eligibility waivers
165.20 and 165.21	Reserved
165.22(312)	Application
165.23(312)	Application procedure
165.24 and 165.25	Reserved
165.26(312)	Evaluation and approval
165.27 to 165.29	Reserved
165.30(312)	Project agreement
165.31 and 165.32	Reserved
165.33(312)	Noncompliance

CHAPTERS 166 to 169
Reserved

LOCAL SYSTEMS

CHAPTER 170
ALLOCATION OF FARM-TO-MARKET ROAD FUNDS

170.1(310)	Purpose
170.2(310)	Contact information
170.3(310)	Temporary allocation

CHAPTER 171
Reserved

CHAPTER 172
AVAILABILITY OF INSTRUCTIONAL MEMORANDUMS
TO LOCAL PUBLIC AGENCIES

172.1(307) Purpose
172.2(307) Contact information
172.3(307) Instructional memorandums to local public agencies

CHAPTER 173
PREPARATION OF SECONDARY ROAD CONSTRUCTION PROGRAMS,
BUDGETS, AND COUNTY ANNUAL REPORTS

173.1(309) Purpose
173.2(309) Contact information
173.3(309) Secondary road construction program
173.4(309) County secondary road budget
173.5(309) County annual report

CHAPTER 174
REIMBURSABLE SERVICES AND SUPPLIES

174.1(307) Purpose
174.2(307) Contact information
174.3(307) Reimbursable services and supplies

CHAPTERS 175 to 177
Reserved

CHAPTER 178
PROJECT COST REPORTING REQUIREMENTS
FOR CITIES AND COUNTIES

178.1(314) Purpose
178.2(314) Contact information
178.3(314) Definitions
178.4(314) Detailed instructions furnished to cities and counties
178.5(314) Project reporting

CHAPTER 179
Reserved

CHAPTER 180
PUBLIC IMPROVEMENT QUOTATION PROCESS FOR GOVERNMENTAL ENTITIES

180.1(314) Purpose
180.2(314) Contact information
180.3(314) Definitions
180.4(314) Types of projects
180.5(314) Solicitation of quotations
180.6(314) Submission of competitive quotation by governmental entity
180.7(314) Form and content of competitive quotations
180.8(314) Evaluation of competitive quotations
180.9(314) Award of contract and subsequent procedures
180.10(314) Retained funds

CHAPTER 181
STATEWIDE STANDARD FOR PERMITTING CERTAIN IMPLEMENTS OF HUSBANDRY

181.1(321) Statewide standard

CHAPTERS 182 to 200
Reserved

INTERMODAL

CHAPTER 201
INTERMODAL PILOT PROJECT PROGRAM

201.1(473) General information
201.2(473) Definitions
201.3(473) Eligibility
201.4(473) Financial assistance
201.5(473) Application procedure
201.6(473) Staff analysis
201.7(473) Staff recommendation
201.8(473) Commission action
201.9(473) Contract preparation and execution
201.10(473) Monitoring

CHAPTERS 202 to 399
Reserved

VEHICLES

CHAPTER 400
VEHICLE REGISTRATION AND CERTIFICATE OF TITLE

400.1(321) Definitions
400.2(321) Vehicle registration and certificate of title—general provisions
400.3(321) Application for certificate of title or registration for a vehicle
400.4(321) Supporting documents required
400.5(321) Where to apply for registration or certificate of title
400.6(17A) Addresses, information and forms
400.7(321) Information appearing on title or registration
400.8(321) Release form for cancellation of security interest
400.9 Reserved
400.10(321) Assignment of security interest
400.11(321) Sheriff's levy, restitution lien, and forfeiture lien noted as security interests
400.12(321) Replacement certificate of title
400.13(321) Bond required before title issued
400.14(321) Transfer of ownership
400.15(321) Cancellation of a certificate of title
400.16(321) Application for certificate of title or original registration for a specially constructed, reconstructed, street rod or replica motor vehicle
400.17 and 400.18 Reserved
400.19(321) Temporary use of vehicle without plates or registration card
400.20(321) Registration of motor vehicle weighing 55,000 pounds or more
400.21(321) Registration of vehicles on a restricted basis
400.22(321) Transfers of ownership by operation of law
400.23(321) Junked vehicle
400.24(321) New vehicle registration fee

400.25(321) Fees established by the department
400.26(321) Anatomical gift
400.27(321,322) Vehicles held for resale or trade by dealers
400.28(321) Special trucks
400.29 Reserved
400.30(321) Registration of vehicles registered in another state or country
400.31 Reserved
400.32(321) Vehicles owned by nonresident members of the armed services
400.33 and 400.34 Reserved
400.35(321) Registration of vehicles equipped for persons with disabilities
400.36(321) Land and water-type travel trailers registration fee
400.37(321) Motorcycle or autocycle primarily designed or converted to transport property
400.38 Reserved
400.39(321) Conversion of motor vehicles
400.40(321) Manufactured or mobile home converted to or from real property
400.41 Reserved
400.42(321) Church bus registration fee
400.43(321) Storage of vehicles
400.44(321) Penalty on registration fees
400.45(321) Suspension, revocation or denial of registration
400.46(321) Termination of suspension of registration
400.47(321) Raw farm products
400.48 and 400.49 Reserved
400.50(321,326) Refund of registration fees
400.51(321) Assigned identification numbers
400.52(321) Odometer statement
400.53(321) Stickers
400.54(321) Registration card issued for trailer-type vehicles
400.55(321) Damage disclosure statement
400.56(321) Hearings
400.57 Reserved
400.58(321) Motorized bicycles
400.59(321) Registration documents lost or damaged in transit through the United States postal service
400.60(321) Credit of registration fees
400.61(321) Reassignment of registration plates
400.62(321) Storage of registration plates, certificate of title forms and registration forms
400.63(321) Disposal of surrendered registration plates
400.64(321) County treasurer's report of motor vehicle collections and funds
400.65 to 400.69 Reserved
400.70(321) Removal of registration and plates by peace officer under financial liability coverage law

CHAPTER 401
SPECIAL REGISTRATION PLATES

401.1(321) Definition
401.2(321) Application, issuance and renewal
401.3 Reserved
401.4(321) Gift certificates
401.5(321) Amateur radio call letter plates
401.6(321) Personalized plates
401.7(321) Collegiate plates

401.8(321) Medal of Honor plates
401.9(321) Firefighter plates
401.10(321) Emergency medical services plates
401.11(321) Natural resources plates
401.12 Reserved
401.13(321) Disabled veteran plates
401.14 Reserved
401.15(321) Processed emblem application and approval process
401.16(321) Special plates with processed emblems—general
401.17(321) State agency-sponsored processed emblem plates
401.18(321) Combat infantryman badge, combat action badge, combat action ribbon, air force combat action medal, combat medical badge, fallen peace officers and civil war sesquicentennial plates
401.19(321) Legion of Merit plates
401.20(321) Persons with disabilities plates
401.21(321) Ex-prisoner of war plates
401.22(321) National guard plates
401.23(321) Pearl Harbor plates
401.24(321) Purple Heart, Silver Star and Bronze Star plates
401.25(321) U.S. armed forces retired plates
401.26 to 401.30 Reserved
401.31(321) Veteran plates
401.32(321) Surrender of plates
401.33(321) Validation fees
401.34(321) Reassignment of plates
401.35(321) Revocation of special registration plates
401.36(321) Refund of fees

CHAPTERS 402 to 404
Reserved

CHAPTER 405
SALVAGE

405.1(321) Applicability
405.2(321) Definitions
405.3(321) Salvage title
405.4 and 405.5 Reserved
405.6(321) Iowa salvage title required
405.7(321) Converting salvage title to regular title
405.8(321) Foreign vehicles
405.9(321) Records check
405.10(321) Designations
405.11 to 405.14 Reserved
405.15(321) Salvage theft examination

CHAPTERS 406 to 409
Reserved

CHAPTER 410
SPECIAL MOBILE EQUIPMENT

410.1(321) General
410.2(321E) Special mobile equipment transported on a registered vehicle

CHAPTER 411
PERSONS WITH DISABILITIES PARKING PERMITS

411.1(321L) Administration
411.2(321L) Application for persons with disabilities parking permit
411.3(321L) Removable windshield placards
411.4(321L) Persons with disabilities special registration plate parking stickers
411.5(321L) Persons with disabilities special registration plates
411.6 Reserved
411.7(321L) Revocation
411.8(321L) Return of parking permit

CHAPTERS 412 to 414
Reserved

CHAPTER 415
DRIVER'S PRIVACY PROTECTION—CERTIFICATES
OF TITLE AND VEHICLE REGISTRATION

415.1(321) Applicability
415.2(321) Adoption
415.3(321) Definitions
415.4(321) Requirements and procedures

CHAPTERS 416 to 423
Reserved

CHAPTER 424
TRANSPORTER PLATES

424.1(321) General
424.2 and 424.3 Reserved
424.4(321) Transporter plates

CHAPTER 425
MOTOR VEHICLE AND TRAVEL TRAILER DEALERS,
MANUFACTURERS, DISTRIBUTORS AND WHOLESALERS

425.1(322) Introduction
425.2 Reserved
425.3(322) Definitions
425.4 to 425.9 Reserved
425.10(322) Application for dealer's license
425.11 Reserved
425.12(322) Motor vehicle dealer's place of business
425.13 Reserved
425.14(322) Travel trailer dealer's place of business
425.15 and 425.16 Reserved
425.17(322) Extension lot license
425.18(322) Supplemental statement of changes
425.19 Reserved
425.20(322) Fleet vehicle sales and retail auction sales
425.21 to 425.23 Reserved
425.24(322) Miscellaneous requirements
425.25 Reserved
425.26(322) Fairs, shows and exhibitions
425.27 and 425.28 Reserved

425.29(322) Classic car permit
425.30(322) Motor truck display permit
425.31(322) Firefighting and rescue show permit
425.32 to 425.39 Reserved
425.40(322) Salespersons of dealers
425.41 to 425.49 Reserved
425.50(322) Manufacturers, distributors, and wholesalers
425.51 and 425.52 Reserved
425.53(322) Wholesaler's financial liability coverage
425.54 to 425.59 Reserved
425.60(322) Right of inspection
425.61 Reserved
425.62(322) Denial, suspension or revocation
425.63 to 425.69 Reserved
425.70(321) Dealer plates
425.71 Reserved
425.72(321) Demonstration permits

CHAPTERS 426 to 429
Reserved

CHAPTER 430
MOTOR VEHICLE LEASING LICENSES
430.1(321F) General
430.2(321F) Application
430.3(321F) Supplemental statements
430.4(321F) Separate licenses required

CHAPTER 431
VEHICLE RECYCLERS
431.1(321H) General
431.2(321H) Criteria for a vehicle recycler license
431.3(321H) Application
431.4(321H) Firm name
431.5(321H) Denial, suspension or revocation of license
431.6(321) Right of inspection

CHAPTERS 432 to 449
Reserved

CHAPTER 450
MOTOR VEHICLE EQUIPMENT
450.1 Reserved
450.2(321) Equipment requirements for specially constructed, reconstructed, street rod, and replica motor vehicles, other than motorcycles and motorized bicycles
450.3(321) Mud and snow tire
450.4(321) Minimum requirements for constructing and equipping specially constructed or reconstructed motorcycles or motorized bicycles
450.5 Reserved
450.6(321) Safety requirements for the movement of implements of husbandry on a roadway
450.7(321) Front windshields, windows or sidewings

CHAPTER 451
EMERGENCY VEHICLE PERMITS

451.1(321) Information
451.2(321) Authorized emergency vehicle certificate
451.3(17A,321) Application denial or certificate revocation

CHAPTER 452
REFLECTIVE DEVICES ON SLOW-MOVING VEHICLES

452.1 and 452.2 Reserved
452.3(321) Alternative reflective device

CHAPTER 453
Reserved

CHAPTER 454
TOWING WRECKED OR DISABLED VEHICLES

454.1(321) Definitions

CHAPTERS 455 to 479
Reserved

CHAPTER 480
ABANDONED VEHICLES

480.1(321) Definitions
480.2(321) Location
480.3(321) General requirements
480.4(321) Abandoned vehicle report
480.5(321) Time limits

CHAPTERS 481 to 499
Reserved

MOTOR CARRIERS

CHAPTER 500
INTERSTATE REGISTRATION AND OPERATION OF VEHICLES

500.1(326) Definitions
500.2(17A,326) General information
500.3(17A,326) Waiver of rules
500.4(326) Renewal for IRP registration
500.5(321) Deadline for placing a vehicle in storage
500.6(321,326) Penalty for late filing of renewal
500.7(326) IRP payment methods
500.8(326) IRP plate
500.9(326) Fleet additions and temporary authority
500.10(326) Fleet deletions
500.11(326) Voluntary cancellation of registration
500.12(326) Policy on registration credit
500.13(326) Penalty for late filing of vehicle schedule
500.14(326) Renewal and vehicle schedule late payment penalty
500.15(321) Deadline for payment of first-half fee
500.16(321,326) Second-half late payment penalty
500.17(326) Duplicate credentials
500.18(326) Suspension for nonpayment of registration fees
500.19(326) Suspension of registration if payment is dishonored by a financial institution

500.20(326) Making claim for refund
500.21(326) Registration expiration and enforcement dates
500.22(326) Registration of vehicles with non-Iowa titles
500.23(326) Record retention
500.24(326) Trip permits
500.25(326) Electronic information

CHAPTERS 501 to 504
Reserved

CHAPTER 505
INTERSTATE MOTOR VEHICLE FUEL LICENSES AND PERMITS
505.1(452A) Definitions
505.2(452A) General information
505.3(452A) General stipulations
505.4(452A) Quarterly reports
505.5(452A) Audits—required reports
505.6(452A) Hearings

CHAPTERS 506 to 510
Reserved

CHAPTER 511
SPECIAL PERMITS FOR OPERATION AND MOVEMENT OF VEHICLES AND LOADS OF EXCESS SIZE AND WEIGHT
511.1(321E) Definitions
511.2(321E) Location and general information
511.3(321E) Movement under permit
511.4(321E) Permits
511.5(321,321E) Fees and charges
511.6(321E) Insurance and bonds
511.7(321,321E) Annual permits
511.8(321,321E) Annual oversize/overweight permits
511.9(321,321E) All-systems permits
511.10(321,321E) Multitrip permits
511.11(321E) Compacted rubbish vehicle permits
511.12(321,321E) Single-trip permits
511.13(321,321E) Maximum axle weights and maximum gross weights for vehicles and loads moved under permit
511.14(321,321E) Movement of vehicles with divisible loads exceeding statutory size or weight limits
511.15(321E) Towing units
511.16(321E) Escorting
511.17(321,321E) Permit violations
511.18(321) Movement of combination vehicles on economic export corridors

CHAPTERS 512 to 519
Reserved

CHAPTER 520
REGULATIONS APPLICABLE TO CARRIERS
520.1(321) Safety and hazardous materials regulations
520.2(321) Definitions
520.3(321) Motor carrier safety regulations exemptions
520.4(321) Hazardous materials exemptions

520.5(321) Safety fitness
520.6(321) Out-of-service order
520.7(321) Driver's statement
520.8(321) Planting and harvesting periods

CHAPTERS 521 to 523
Reserved

CHAPTER 524
FOR-HIRE INTRASTATE MOTOR CARRIER AUTHORITY

524.1(325A) Purpose and applicability
524.2(325A) General information
524.3(325A) Applications and supporting documents
524.4(325A) Issuance of credentials
524.5(325A) Duplicate motor carrier permit or motor carrier certificate
524.6(325A) Amendment to a motor carrier permit or certificate
524.7(325A) Insurance—suspension
524.8(325A) Self-insurance for motor carriers of passengers
524.9(325A) Safety self-certification
524.10(325A) Financial statement
524.11(325A) Safety education seminar
524.12(325A) Marking of motor vehicles
524.13(325A) Bills of lading or freight receipts
524.14(325A) Lease of a vehicle
524.15(325A) Tariffs
524.16 Reserved
524.17(325A) Suspension, revocation or reinstatement
524.18(325A) Hearings

CHAPTERS 525 to 528
Reserved

CHAPTER 529
FOR-HIRE INTERSTATE MOTOR CARRIER AUTHORITY

529.1(327B) Motor carrier regulations
529.2(327B) Registering interstate authority in Iowa
529.3(327B) Waiver of rules

CHAPTERS 530 to 539
Reserved

CHAPTER 540
TRANSPORTATION NETWORK COMPANIES

540.1(321N) Purpose and applicability
540.2(321N) Definitions
540.3(321N) General information
540.4(321N) Application for transportation network company permit and supporting documents
540.5(321N) Issuance of permit
540.6(321N) Amendment to transportation network company permit
540.7(321N) Suspension
540.8(321N) Revocation
540.9(321N) Appeal
540.10(321N) Renewal

CHAPTERS 541 to 599
Reserved

DRIVER LICENSES

CHAPTER 600
GENERAL INFORMATION

600.1(321) Definitions
600.2(17A) Information and location
600.3(321) Persons exempt
600.4(252J,261,321) Persons not to be licensed
600.5 to 600.15 Reserved
600.16(321) Seat belt exemptions

CHAPTER 601
APPLICATION FOR LICENSE

601.1(321) Application for license
601.2(321) Surrender of license and nonoperator's identification card
601.3 and 601.4 Reserved
601.5(321) Proofs submitted with application
601.6(321) Parental consent
601.7(321) REAL ID driver's license

CHAPTER 602
CLASSES OF DRIVER'S LICENSES

602.1(321) Driver's licenses
602.2(321) Information and forms
602.3 Reserved
602.4(321) Definitions of immediate family
602.5 to 602.10 Reserved
602.11(321) Class C noncommercial driver's license
602.12(321) Class D noncommercial driver's license (chauffeur)
602.13(321) Class M noncommercial driver's license (motorcycle)
602.14(321) Transition from five-year to eight-year licenses
602.15(321) Minor's restricted license
602.16 Reserved
602.17(321) Minor's school license
602.18(321) Motorcycle instruction permit
602.19(321) Noncommercial instruction permit
602.20 Reserved
602.21(321) Special noncommercial instruction permit
602.22 Reserved
602.23(321) Chauffeur's instruction permit
602.24(321) Motorized bicycle license
602.25(321) Minor's restricted license
602.26(321) Minor's school license

CHAPTER 603
Reserved

CHAPTER 604
LICENSE EXAMINATION

604.1(321) Authority and scope
604.2(321) Definitions

604.3(17A) Information and forms
604.4 to 604.6 Reserved
604.7(321) Examination
604.8 and 604.9 Reserved
604.10(321) Vision screening
604.11(321) Vision standards
604.12(321) Vision referrals
604.13(321) Vision screening results
604.14 to 604.19 Reserved
604.20(321) Knowledge test
604.21(321) Knowledge test requirements and waivers
604.22(321) Knowledge test results
604.23 to 604.29 Reserved
604.30(321) Driving test
604.31(321) Driving test requirements and waivers for noncommercial driver's licenses
604.32 to 604.34 Reserved
604.35(321) Determination of gross vehicle weight rating
604.36 to 604.39 Reserved
604.40(321) Failure to pass examination
604.41 to 604.44 Reserved
604.45(321) Reinstatement
604.46 to 604.49 Reserved
604.50(321) Special reexaminations

CHAPTER 605
LICENSE ISSUANCE

605.1(321) Scope
605.2(321) Contents of license
605.3(321) License class
605.4(321) Endorsements
605.5(321) Restrictions
605.6(321) License term for temporary foreign national
605.7 and 605.8 Reserved
605.9(321) Fees for driver's licenses
605.10 Reserved
605.11(321) Duplicate license
605.12(321) Address changes
605.13 and 605.14 Reserved
605.15(321) License extension
605.16(321) Military extension
605.17 to 605.19 Reserved
605.20(321) Fee adjustment for upgrading license
605.21 to 605.24 Reserved
605.25(321) License renewal

CHAPTER 606
Reserved

CHAPTER 607
COMMERCIAL DRIVER LICENSING

607.1(321) Scope
607.2(17A) Information
607.3(321) Definitions

607.4 and 607.5 Reserved
607.6(321) Exemptions
607.7(321) Records
607.8 and 607.9 Reserved
607.10(321) Adoption of federal regulations
607.11 to 607.14 Reserved
607.15(321) Application
607.16(321) Commercial driver's license (CDL)
607.17(321) Endorsements
607.18(321) Restrictions
607.19 Reserved
607.20(321) Commercial learner's permit
607.21 to 607.24 Reserved
607.25(321) Examination for a commercial driver's license
607.26(321) Vision screening
607.27(321) Knowledge tests
607.28(321) Skills test
607.29 Reserved
607.30(321) Third-party testing
607.31(321) Test results
607.32 to 607.34 Reserved
607.35(321) Issuance of commercial driver's license and commercial learner's permit
607.36 Reserved
607.37(321) Commercial driver's license renewal
607.38(321) Transfers from another state
607.39(321) Disqualification
607.40(321) Sanctions
607.41 to 607.44 Reserved
607.45(321) Reinstatement
607.46 to 607.48 Reserved
607.49(321) Restricted commercial driver's license
607.50(321) Self-certification of type of driving and submission of medical examiner's certificate
607.51(321) Determination of gross vehicle weight rating

CHAPTERS 608 and 609
Reserved

CHAPTER 610
RELEASE OF COMPUTERIZED DRIVER'S LICENSE
AND NONOPERATOR'S IDENTIFICATION CARD RECORDS
610.1(321) Applicability
610.2(321) Definitions
610.3(321) Copying files to computer tape cartridges
610.4(321,321A) Certified abstract of operating records

CHAPTER 611
DRIVER'S PRIVACY PROTECTION—DRIVER'S LICENSE
AND NONOPERATOR'S IDENTIFICATION CARD
611.1(321) Applicability
611.2(321) Adoption
611.3(321) Definitions
611.4(321) Requirements and procedures

CHAPTERS 612 to 614
Reserved

CHAPTER 615
SANCTIONS

615.1(321)	Definitions
615.2(321)	Scope
615.3(17A)	Information and address
615.4(321)	Denial for incapability
615.5 and 615.6	Reserved
615.7(321)	Cancellations
615.8	Reserved
615.9(321)	Habitual offender
615.10	Reserved
615.11(321)	Periods of suspension
615.12(321)	Suspension of a habitually reckless or negligent driver
615.13(321)	Suspension of a habitual violator
615.14(321)	Suspension for incapability
615.15(321)	Suspension for unlawful use of a license
615.16(321)	Suspension for out-of-state offense
615.17(321)	Suspension for a serious violation
615.18(321)	Suspension under the nonresident violator compact
615.19(321)	Suspension for a charge of vehicular homicide
615.20(321)	Suspension for moving violation during probation
615.21(321)	Suspension of a minor's school license and minor's restricted license
615.22(321)	Suspension for nonpayment of fine, penalty, surcharge or court costs
615.23(321)	Suspensions for juveniles
615.24(252J,261)	Suspension upon receipt of a certificate of noncompliance
615.25	Reserved
615.26(321)	Suspension or revocation for violation of a license restriction
615.27 and 615.28	Reserved
615.29(321)	Mandatory revocation
615.30(321)	Revocation for out-of-state offense
615.31	Reserved
615.32(321)	Extension of revocation period
615.33(321)	Revocation of a minor's license
615.34 and 615.35	Reserved
615.36(321)	Effective date of suspension, revocation, disqualification or bar
615.37(321)	Service of notice
615.38(17A,321)	Hearing and appeal process
615.39(321)	Surrender of license
615.40(321)	License reinstatement or reissue
615.41(321)	Investigation of convictions based on fraud
615.42(321)	Remedial driver improvement action under Iowa Code section 321.180B
615.43(321)	Driver improvement program
615.44(321)	Driver improvement interview
615.45(321)	Temporary restricted license (work permit)

CHAPTERS 616 to 619
Reserved

CHAPTER 620
OWI AND IMPLIED CONSENT

620.1	Reserved
620.2(321J)	Information and location
620.3(321J)	Issuance of temporary restricted license
620.4(321J)	Hearings and appeals
620.5(321J)	Reinstatement
620.6(321J)	Issuance of temporary restricted license after revocation period has expired
620.7 to 620.9	Reserved
620.10(321J)	Revocation for deferred judgment
620.11 to 620.14	Reserved
620.15(321J)	Substance abuse evaluation and treatment or rehabilitation services
620.16(321J)	Drinking drivers course

CHAPTERS 621 to 624
Reserved

CHAPTER 625
DRIVER'S LICENSES FOR UNDERCOVER
LAW ENFORCEMENT OFFICERS

625.1(321)	Purpose
625.2(321)	Application
625.3(321)	Issuance
625.4(321)	Renewal not permitted
625.5(321)	Cancellation
625.6(321)	Records

CHAPTERS 626 to 629
Reserved

CHAPTER 630
NONOPERATOR'S IDENTIFICATION

630.1(321)	General information
630.2(321)	Application and issuance
630.3(321)	Duplicate card
630.4(321)	Cancellation

CHAPTERS 631 to 633
Reserved

CHAPTER 634
DRIVER EDUCATION

634.1(321)	Information and location
634.2(321)	Definition
634.3	Reserved
634.4(321)	Driver education course standards and requirements
634.5	Reserved
634.6(321)	Teacher qualifications
634.7(321)	Behind-the-wheel instructor's certification
634.8(321)	Private and commercial driver education schools
634.9 and 634.10	Reserved
634.11(321)	Driver education—teaching parent

CHAPTER 635
MOTORCYCLE RIDER EDUCATION (MRE)

635.1(321) Definitions
635.2(321) Approved course in motorcycle rider education
635.3(321) Instructors
635.4(321) Responsibilities of sponsors
635.5(321) Use of motorcycle rider education fund
635.6(321) Information and location
635.7(321) License issuance

CHAPTER 636
MOTORIZED BICYCLE RIDER EDUCATION

636.1(321) Information and location
636.2(321) Definitions
636.3 Reserved
636.4(321) Agencies or institutions
636.5(321) Private or commercial sponsors
636.6 Reserved
636.7(321) Course requirements
636.8(321) Teacher qualifications
636.9(321) Evaluation

CHAPTERS 637 to 639
Reserved

CHAPTER 640
FINANCIAL RESPONSIBILITY

640.1(321A) General provisions
640.2(321A) Hearing and appeal process
640.3(321A) Accident reporting requirements
640.4(321A) Security required following accident
640.5(321A) Judgments
640.6(321A) Proof of financial responsibility for the future
640.7(321A) Transfer of suspended registration

CHAPTER 641
FINANCIAL LIABILITY COVERAGE CARDS

641.1(321) Purpose and applicability
641.2(321) Definitions
641.3(321) Content of financial liability coverage card
641.4(321) Responsibilities of insurer
641.5(321) Acquisition of additional or replacement motor vehicles
641.6(321) New policies

CHAPTERS 642 to 699
Reserved

AERONAUTICS

CHAPTER 700
AERONAUTICS ADMINISTRATION

700.1(328) Definitions
700.2(17A) Information and forms
700.3(17A) Hearing and appeal process

CHAPTERS 701 to 709
Reserved

CHAPTER 710
AIRPORT IMPROVEMENT PROGRAM

710.1(328) Purpose
710.2(328) Definitions
710.3(17A) Information and forms
710.4(330) Federal airport improvement funds
710.5(328) State airport improvement funds

CHAPTERS 711 to 714
Reserved

CHAPTER 715
AIR SERVICE DEVELOPMENT PROGRAM

715.1(328) Purpose
715.2(328) Definitions
715.3(328) Eligibility and funding
715.4(328) Eligible project activities
715.5 Reserved
715.6(328) Project selection criteria
715.7(328) Application
715.8(328) Project administration

CHAPTER 716
COMMERCIAL SERVICE VERTICAL INFRASTRUCTURE PROGRAM

716.1(328) Purpose
716.2(328) Definitions
716.3(328) Information and forms
716.4(328) Eligible airports
716.5(328) Eligible project activities
716.6 Reserved
716.7(328) Project application and review
716.8(328) Project administration

CHAPTER 717
GENERAL AVIATION VERTICAL INFRASTRUCTURE PROGRAM

717.1(328) Purpose
717.2(328) Definitions
717.3(328) Information and forms
717.4(328) Applicant eligibility
717.5(328) Eligible project activities
717.6 Reserved
717.7(328) Funding
717.8(328) Project priorities
717.9(328) Project applications
717.10(328) Review and approval
717.11(328) Project administration

CHAPTERS 718 and 719
Reserved

CHAPTER 720
IOWA AIRPORT REGISTRATION

720.1(328)	Scope
720.2(328)	Definitions
720.3(328)	Airport site approval required
720.4(328)	Public-use airport
720.5(328)	Private-use airport
720.6(328)	Revocation or denial
720.7 to 720.9	Reserved
720.10(328)	Minimum safety standards
720.11 to 720.14	Reserved
720.15(328)	Airport closing

CHAPTERS 721 to 749
Reserved

CHAPTER 750
AIRCRAFT REGISTRATION

750.1(328)	Purpose
750.2(328)	Definitions
750.3(17A)	Information and forms
750.4 to 750.8	Reserved
750.9(328)	Registration
750.10(328)	First registration procedure
750.11 to 750.14	Reserved
750.15(328)	Aircraft not airworthy
750.16 to 750.19	Reserved
750.20(328)	Renewal notice
750.21 to 750.28	Reserved
750.29(328)	Penalty on registration fees
750.30(328)	Lien

CHAPTERS 751 to 799
Reserved

RAILROADS

CHAPTER 800
ITEMS OF GENERAL APPLICATION FOR RAILROADS

800.1(307)	Definitions
800.2(17A)	Location and submission of documents
800.3(327C)	Accounts
800.4(327C)	Annual reports
800.5 to 800.14	Reserved
800.15(327F)	Train speed ordinances
800.16 to 800.19	Reserved
800.20(327G)	Removal of tracks from crossings

CHAPTER 801
Reserved

CHAPTER 802
REPORTING OF RAILROAD ACCIDENTS/INCIDENTS

802.1(327C) Written reports
802.2(327C) Immediate reporting of personal injury or death

CHAPTERS 803 to 809
Reserved

CHAPTER 810
RAILROAD SAFETY STANDARDS

810.1(327C) Track standards
810.2(327C) Track inspection
810.3 Reserved
810.4(327F) First aid and medical treatment for railroad employees
810.5(327F) Worker transportation

CHAPTER 811
HIGHWAY-RAILROAD GRADE CROSSING WARNING DEVICES

811.1(307) Standards

CHAPTER 812
CLASSIFICATIONS AND STANDARDS FOR
HIGHWAY-RAILROAD GRADE CROSSINGS

812.1(307) Purpose
812.2(307) Classification
812.3(307) Warning device standards and their implementation
812.4(307) Effect of rules

CHAPTER 813
CLOSE-CLEARANCE WARNING SIGNS ALONG RAILROAD TRACKS

813.1(327F) Purpose and scope
813.2(327F) Applicability
813.3(327F) Information
813.4(327F) Definitions
813.5(327F) Close-clearance dimensions
813.6(327F) Signing requirements
813.7 and 813.8 Reserved
813.9(327F) Enforcement
813.10(327F) Reimbursement

CHAPTERS 814 to 819
Reserved

CHAPTER 820
HIGHWAY GRADE CROSSING SAFETY FUND

820.1(327G) Definitions
820.2(327G) Purpose
820.3(327G) Information and submissions
820.4(327G) Participation in the maintenance costs of eligible warning devices
820.5(327G) Reimbursement

CHAPTER 821
HIGHWAY-RAILROAD GRADE CROSSING SURFACE
REPAIR FUND

821.1(327G) Definitions
821.2(327G) General information
821.3(327G) Procedures for the use of grade crossing surface repair funds

CHAPTER 822
RAILROAD REVOLVING LOAN AND GRANT FUND PROGRAM

822.1(327H) Introduction
822.2(327H) Definitions
822.3(327H) Information
822.4(327H) Purpose of program
822.5(327H) Funding
822.6(327H) Project criteria
822.7(327H) Applicant eligibility
822.8(327H) Eligible and ineligible project costs
822.9 Reserved
822.10(327H) Project application
822.11(327H) Project evaluation and approval
822.12(327H) Project agreement and administration

CHAPTERS 823 to 899
Reserved

PUBLIC TRANSIT

CHAPTERS 900 to 909
Reserved

CHAPTER 910
COORDINATION OF PUBLIC TRANSIT SERVICES

910.1(324A) Definitions
910.2(17A) Information and location
910.3(324A) Statewide transportation coordination advisory council
910.4(324A) Certification process
910.5(324A) Standards for compliance
910.6(324A) Noncompliance
910.7(324A) Noncompliant sanctions
910.8(17A,324A) Revocation

CHAPTER 911
SCHOOL TRANSPORTATION SERVICES PROVIDED
BY REGIONAL TRANSIT SYSTEMS

911.1(321) Purpose and information
911.2(321,324A) Definitions
911.3(321) Services to students as part of the general public
911.4(321) Contracts for nonexclusive school transportation
911.5(321) Adoption of federal regulations
911.6(321) Driver standards
911.7(321) Vehicle standards
911.8(321) Maintenance
911.9(321) Safety equipment
911.10(321) Operating policies

CHAPTERS 912 to 919
Reserved

CHAPTER 920
STATE TRANSIT ASSISTANCE

920.1(324A) Statement of policy
920.2(324A) General information
920.3(324A) Definitions
920.4(324A) Types of projects
920.5(324A) Standards for projects
920.6(324A) Processing

CHAPTER 921
ADVANCED ALLOCATIONS OF STATE TRANSIT ASSISTANCE FUNDING

921.1(324A) Scope of chapter
921.2(324A) Advance allocations
921.3(324A) Application for advance allocations
921.4(324A) Application approval
921.5(324A) Consideration in determining the approval of advance allocation application
921.6 Reserved
921.7(324A) Reports, and suspension and termination of allocations
921.8(324A) Income derived from interest-bearing accounts and investments
921.9(324A) Joint participation agreement close and audits

CHAPTER 922
FEDERAL TRANSIT ASSISTANCE

922.1(324A) Projects for nonurbanized areas and private nonprofit transportation providers

CHAPTER 923
CAPITAL MATCH REVOLVING LOAN FUND

923.1(71GA,ch265) General information
923.2(71GA,ch265) Definitions
923.3(71GA,ch265) System eligibility
923.4(71GA,ch265) Project eligibility
923.5(71GA,ch265) Procedure

CHAPTER 924
PUBLIC TRANSIT INFRASTRUCTURE GRANT PROGRAM

924.1(324A) Purpose
924.2(324A) Definitions
924.3(324A) Information and forms
924.4 and 924.5 Reserved
924.6(324A) Project eligibility
924.7(324A) Eligible project activities
924.8(324A) Ineligible project activities
924.9 Reserved
924.10(324A) Funding
924.11(324A) Project applications
924.12 and 924.13 Reserved
924.14(324A) Project priorities
924.15(324A) Review and approval
924.16(324A) Project agreement, administration and ownership

CHAPTER 511
SPECIAL PERMITS FOR OPERATION AND MOVEMENT OF VEHICLES AND LOADS OF EXCESS SIZE AND WEIGHT

[Appeared as Ch 2, Highway Commission, 1973 IDR; amended in July 1974 and January and July 1975 Supplements]
[Previously numbered as (07,E) Ch 12, transferred at the request of the department on 10/8/75]
[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 2]

761—511.1(321E) Definitions. As used in this chapter, unless the context otherwise requires:

"Compacted rubbish vehicle" means any vehicle hauling rubbish that has been mechanically compacted with a hydraulic, electric, or air-operated ram.

"Department" means the Iowa department of transportation.

"Dimensions" or *"size"* means length, width or height limits.

"Indivisible load" means any load or vehicle exceeding applicable length or weight limits which, if separated into smaller loads or vehicles, would:

1. Compromise the intended use of the vehicle, i.e., make it unable to perform the function for which it was intended;
2. Destroy the value of the load or vehicle, i.e., make it unusable for its intended purpose; or
3. Require more than eight work hours to dismantle using appropriate equipment. The applicant for an indivisible load permit has the burden of proof as to the number of work hours required to dismantle the load.

"Overdimensional" or *"oversize"* means the exceeding of statutory length, width or height limits.

"Permit" means a permit issued under Iowa Code chapter 321E for the movement of an overdimensional or overweight vehicle, combination of vehicles, or vehicle with load. The term includes any additions or supplements thereto issued by the permit-issuing authority.

"Permit-issuing authority" means the:

1. Department's office of vehicle and motor carrier services for permits for movement on the primary road system.
2. Authority responsible for the maintenance of a nonprimary system of highways or streets for permits for movement on that system. However, the office of vehicle and motor carrier services may issue single-trip permits on primary road extensions in cities in conjunction with movement on the rural primary road system.

"Primary roads" or *"primary road system"* is defined in Iowa Code section 306.3. The primary road system includes the interstate road system.

"Rubbish" means any unwanted or useless material that has no commercial or practical value or use and that would normally be discarded.

"Special or emergency situation" means one or more of the following:

1. Circumstances where the movement is necessary to cooperate with cities, counties, other state agencies or other states in response to a national or other disaster.
2. Circumstances where the movement is necessary to cooperate with national defense officials.
3. Circumstances where the movement is necessary to cooperate with public or private utilities in order to maintain their public services.
4. Circumstances where the movement is essential to ensure safety and protection of any person or property due to an event such as, but not limited to, pollution of natural resources, a potential fire or an explosion.
5. Circumstances where weather or transportation problems create an undue hardship for citizens of the state of Iowa.
6. Circumstances where the movement involves emergency-type vehicles.
7. Uncommon or extraordinary circumstances where the movement is essential to the existence of an Iowa business and the move may be accomplished without causing undue hazards to the safety of the traveling public or undue damage to private or public property.
8. Other unique circumstances that warrant the issuance of a permit as determined by the permit-issuing authority.

"Statutory" when used with size or weight limits refers to those limits found in Iowa Code chapter 321.

This rule is intended to implement Iowa Code sections 321E.9, 321E.15, 321E.29, 321E.30 and 321E.34.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.2(321E) Location and general information.

511.2(1) Applications, forms, instructions and restrictions are available on the department's Web site at www.iowadot.gov and by mail from the Office of Vehicle and Motor Carrier Services, Iowa Department of Transportation, P.O. Box 10382, Des Moines, Iowa 50306-0382; in person at 6310 SE Convenience Blvd., Ankeny, Iowa; by telephone at (515)237-3264; or by facsimile at (515)237-3257. Permits may be obtained electronically upon making application to the office of vehicle and motor carrier services.

511.2(2) No overdimensional or overweight vehicle, combination of vehicles, or vehicle with load shall be moved on the highways of this state without permit except as provided in Iowa Code section 321.453.

511.2(3) Rescinded IAB 2/7/01, effective 3/14/01.

511.2(4) Except as provided in subrule 511.7(6) and rule 761—511.14(321,321E), permits may be issued only for the transporting of a single article which exceeds statutory size or weight limits or both, and which cannot reasonably be divided or reduced to statutory size and weight limits. However, permits may be issued for the transporting of property consisting of more than one article when:

a. The statutory weight limits are not exceeded,

b. One of the articles exceeds the statutory size limits, and

c. The inclusion of other articles does not cause the statutory size limits to be exceeded by an additional amount.

511.2(5) Nothing in the permit shall be construed as waiving any load limits which have been or which might be established on any bridge or any road which is posted with embargo signs, unless specifically stated on the permit.

511.2(6) The state of Iowa, the department, and any other permit-issuing authority assume no responsibility for the property of the permit holder. Permit holders shall hold permit-issuing authorities harmless of any damages that may be sustained by the traveling public, adjacent property owners or the highways of this state on account of movements made under permit.

This rule is intended to implement Iowa Code sections 17A.3 and 321E.2.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.3(321E) Movement under permit.

511.3(1) During the movement of a vehicle or object under permit, the permit holder shall comply with the terms and conditions of the permit and shall take all reasonable precautions to protect and safeguard the lives and property of the traveling public and adjacent property owners.

511.3(2) Movement shall be made only when roads are clear of ice and snow and visibility is at least one-quarter mile. Snow removal equipment operating under permit is exempt from this restriction while snow removal operations are conducted. EXCEPTION: Nothing in this subrule shall be construed to mean that the movement of a compacted rubbish vehicle permitted under rule 761—511.11(321E) shall be subject to this restriction.

511.3(3) Movement shall be permitted only during the hours from one-half hour before sunrise to one-half hour after sunset unless it is established by the permit-issuing authority that the movement can be better accomplished at another period of time because of traffic volume conditions.

511.3(4) Except as provided in Iowa Code section 321.457, no movement shall be permitted on the holidays of Memorial Day, Independence Day and Labor Day, after 12 noon on days preceding these holidays and holiday weekends, during holiday weekends, or during special events when abnormally high traffic volumes can be expected. A holiday weekend occurs when the holiday falls on Friday, Saturday, Sunday or Monday. No movement shall be permitted until one-half hour before sunrise on the day after the holiday or holiday weekend.

511.3(5) Continuous moves. Vehicles and loads may travel by permit between one-half hour after sunset and one-half hour before sunrise if, in addition to the general provisions and general requirements specified by the permit, the following conditions are met.

a. Dimensions shall not exceed:

(1) Width. 11 feet.

(2) Height. 14 feet, 6 inches.

(3) Length. 100 feet.

(4) Weight. Legal axle limits.

b. Travel must be on roadways with a minimum width of 22 feet and minimum lane width of 11 feet.

c. Safety lighting shall be provided at the widest part of a load. The lamps may be placed at the outer ends of the load itself or on appurtenances which are equal in width to the widest part of the load and positioned at both the extreme front and rear of the vehicle or trailer as follows:

(1) One lighted red lamp on each side at the rear of the load.

(2) One lighted yellow or amber lamp on each side at the front of the load.

This rule is intended to implement Iowa Code sections 321E.2 and 321E.11.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.4(321E) Permits. Permits issued shall be in writing or in electronic format and may be either single-trip, multitrip, annual, annual oversize/overweight, compacted rubbish or all-systems permits.

511.4(1) *Methods of issuance.*

a. Permits for movement on the primary road system may be obtained in person, by facsimile, online, or by mail at the address in subrule 511.2(1).

b. Reserved.

511.4(2) *Forms.*

a. Applications for permits for movement on the primary road system shall be made online or on a form prescribed by the department.

b. Any applications to other permit-issuing authorities made upon department forms shall be sufficient and accepted as properly made by these authorities.

c. Subject to the preceding paragraph, permit-issuing authorities may adopt, amend or modify these forms provided that the amended or modified forms adequately identify the applicant, the hauling vehicle and load, the manner and extent that the vehicle with load exceeds the statutory size and weight limits, the route, and the authorization of the issuing authority. However, the load for a multitrip permit does not have to be identified but the vehicle and load cannot exceed either the weight per axle or the total weight identified on the multitrip permit. Axle spacings cannot change.

511.4(3) *Validity.*

a. Annual, annual oversize/overweight, compacted rubbish, and all-systems permits shall expire one year from the date of issuance.

b. A single-trip permit shall be effective for five days.

c. The validity of a multitrip permit shall not exceed 60 calendar days.

511.4(4) *Duplicate permit.* If a permit is lost or destroyed before it has expired, a duplicate permit may be issued at the discretion of the permit-issuing authority. The expiration date on the duplicate permit shall be the same as on the original permit.

This rule is intended to implement Iowa Code sections 321E.2 and 321E.3.

[**ARC 0136C**, IAB 5/30/12, effective 7/4/12; **ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.5(321,321E) Fees and charges.

511.5(1) *Annual oversize permit.* A fee of $50 shall be charged for each annual permit issued pursuant to Iowa Code section 321E.8, payable prior to the issuance of the permit. Carriers purchasing annual permits in advance of use cannot return unused permits for refunds.

511.5(2) *Annual oversize permit for certain divisible loads.* A fee of $25 shall be charged for each annual permit issued pursuant to Iowa Code section 321E.29, payable prior to the issuance of the permit. Only divisible loads of hay, straw, stover, or bagged livestock bedding are permitted under this permit.

511.5(3) *Annual oversize/overweight permit.* A fee of $400 shall be charged for each annual oversize/overweight permit, payable prior to the issuance of the permit. Transfer of current annual oversize/overweight permit to a replacement vehicle may be allowed when the original vehicle has been damaged in an accident, junked or sold.

511.5(4) *All-systems permit.* A fee of $160 shall be charged for each annual all-systems permit, payable prior to the issuance of the permit.

511.5(5) *Bridge-exempt permit.* A fee of $25 shall be charged for each bridge-exempt permit issued pursuant to Iowa Code section 321E.7, payable prior to the issuance of the permit.

511.5(6) *Multitrip permit.* A fee of $200 shall be charged for each multitrip permit, payable prior to the issuance of the permit.

511.5(7) *Raw milk permit.* A fee of $25 shall be charged for each raw milk permit issued pursuant to Iowa Code section 321E.29A, payable prior to the issuance of the permit.

511.5(8) *Single-trip permit.* A fee of $35 shall be charged for each single-trip permit, payable prior to the issuance of the permit.

511.5(9) *Compacted rubbish permit.* A fee of $100 shall be charged for each compacted rubbish permit, payable prior to the issuance of the permit.

511.5(10) *Duplicate permit.* A fee of $2 shall be charged for each duplicate permit, payable prior to the issuance of the permit.

511.5(11) *Registration fee.* A registration fee shall be charged for vehicles transporting buildings, except mobile homes and factory-built structures, on a single-trip basis. The vehicle shall be registered for the combined gross weight of the vehicle and load. The fee shall be 5 cents per ton exceeding the weight registered under Iowa Code section 321.122 per mile of travel and shall be payable prior to the issuance of the permit. Fees shall not be prorated for fractions of miles.

511.5(12) *Fair and reasonable costs.* Permit-issuing authorities may charge any permit applicant:

a. A fair and reasonable cost for the removal and replacement of natural obstructions or official signs and signals.

b. A fair and reasonable cost for measures necessary to avoid damage to public property including structures and bridges.

511.5(13) *Methods of payment.* Fees and costs required under this chapter shall normally be paid by credit card, certified check, cashier's check, traveler's check, bank draft or cash. Personal checks may be accepted at the discretion of the permit-issuing authority.

This rule is intended to implement Iowa Code sections 321.12, 321.122, 321E.14, 321E.29, 321E.29A and 321E.30.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.6(321E) Insurance and bonds.

511.6(1) *Insurance.*

a. Public liability insurance in the amounts of $100,000 bodily injury each person, $200,000 bodily injury each occurrence, and $50,000 property damage with an expiration date to cover the tenure of the annual, annual oversize/overweight, all-systems, multitrip or single-trip permit shall be required. In lieu of filing with the permit-issuing authority, a copy of the current certificate of public liability insurance in these amounts shall be carried in the vehicle for which the permit has been issued. Proof of liability insurance may be either in writing or in electronic format.

b. Notwithstanding paragraph *"a"* of this subrule, a carrier may act as a self-insurer if an application for self-insurance is filed with and approved by the department.

511.6(2) *Bond.*

a. The permit-issuing authority may require the applicant to file a bond, certified check or other assurance in an amount sufficient to cover the reasonably anticipated cost of damage or loss to private property, either real or personal, likely to be caused by or arising out of the movement of the vehicle and load or to ensure compliance with permit provisions.

b. The amount in the preceding paragraph may be reduced either in whole or in part by the applicant's submission to the permit-issuing authority of written permission from an affected third party

stating in substance that the third party either owns or has the right of exclusive possession and control over the affected property, does by the party's signature consent to the move and that the applicant has in hand paid or secured the payment of the anticipated cost of loss or damage to the party's property.

This rule is intended to implement Iowa Code section 321E.13.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.7(321,321E) Annual permits. Annual permits are issued for indivisible vehicles or indivisible loads for travel when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The owner or operator shall select a route using the vertical clearance map and road construction and travel restrictions map provided by the department. Detour and road embargo information may also be found online at: www.511ia.org. Prior to making the move, the owner or operator shall contact the department by telephone at (515)237-3264 between 8 a.m. and 4:30 p.m., Monday through Friday, except for legal holidays, to verify that the owner or operator is using the most recent information. Annual permits are issued for the following:

511.7(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 12 feet 5 inches including appurtenances.

b. *Length.* 120 feet 0 inches overall.

c. *Height.* 13 feet 10 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Movement is allowed for unlimited distance; routing through the office of vehicle and motor carrier services is not required.

511.7(2) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 14 feet 6 inches.

b. *Length.* 120 feet 0 inches overall.

c. *Height.* 15 feet 5 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Movement is restricted to 50 miles unless trip routes are obtained from the office of vehicle and motor carrier services or the route continues on at least four-lane roads. Trip routes are valid for five days.

511.7(3) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 16 feet 0 inches.

b. *Length.* 120 feet 0 inches.

c. *Height.* 15 feet 5 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Trip routes must be obtained from the office of vehicle and motor carrier services.

511.7(4) Rescinded IAB 1/23/02, effective 2/27/02.

511.7(5) Truck trailers manufactured or assembled in the state of Iowa provided the following are met:

a. *Width.* Not to exceed 10 feet 0 inches.

b. *Length.* Overall combination length must comply with Iowa Code section 321.457.

c. *Height.* Statutory: Not to exceed 13 feet 6 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Speed.* Rescinded IAB 2/7/01, effective 3/14/01.

f. *Roadway width.* At least 24 feet 0 inches.

g. *Limited movement.* Movement shall be solely for the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and shall be on the most direct route necessary for the movement.

511.7(6) Vehicles with divisible loads of hay, straw, stover, or bagged livestock bedding provided the following are not exceeded:

a. *Width.* 12 feet 5 inches.

b. *Length.* Statutory: 75 feet.

c. *Height.* Statutory: 14 feet 6 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Unlimited.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10, 321E.29 and 321E.29A.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.8(321,321E) Annual oversize/overweight permits. Annual oversize/overweight permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. Travel is not allowed on the interstate. However, a carrier moving under this annual oversize/overweight permit may operate under the same restrictions as an annual permit under rule 511.7(321,321E) when the vehicle meets the dimensions required by that rule. Routing is subject to embargoed bridges and roads and posted speed limits. Annual oversize/overweight permits are issued for the following:

511.8(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 13 feet 5 inches.

b. *Length.* 120 feet 0 inches.

c. *Height.* 15 feet 5 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Routing.* The owner or operator shall select a route using a vertical clearance map, kip map, bridge embargo map and detour and road embargo map provided by the department. Detour and road embargo information may also be found online at www.511ia.org. The owner or operator shall contact the department by telephone at (515)237-3264 between 8 a.m. and 4:30 p.m., Monday through Friday, except for legal holidays, prior to making the move to verify that the owner or operator is using the most recent information.

511.8(2) Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, and 321E.8.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.9(321,321E) All-systems permits. All-systems permits are issued by the office of vehicle and motor carrier services for indivisible vehicles or indivisible loads for travel on the primary road system and specified city streets and county roads when the dimensions of the vehicle or load exceed statutory limits but the weight is within statutory limits. Routing is subject to embargoed bridges and roads and posted speed limits. The office of vehicle and motor carrier services will provide a list of the authorized city streets and county roads. Permit holders shall consult with local officials when traveling on county roads or city streets for bridge embargo, vertical clearance, detour, and road construction information. These permits are issued for the following:

511.9(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 12 feet 5 inches including appurtenances.

b. *Length.* 120 feet 0 inches overall.

c. *Height.* 13 feet 10 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Movement is allowed for unlimited distance; routing through the office of vehicle and motor carrier services and city and county jurisdictions is not required.

511.9(2) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 14 feet 6 inches.

b. *Length.* 120 feet 0 inches overall.

c. *Height.* 15 feet 5 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Movement is restricted to 50 miles unless trip routes are obtained from the office of vehicle and motor carrier services and city and county jurisdictions or the route continues on at least four-lane roads. Trip routes are valid for five days.

511.9(3) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 16 feet 0 inches.

b. *Length.* 120 feet 0 inches.

c. *Height.* 15 feet 5 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Trip routes must be obtained from the office of vehicle and motor carrier services and city and county jurisdictions.

511.9(4) Rescinded IAB 1/23/02, effective 2/27/02.

511.9(5) Truck trailers manufactured or assembled in the state of Iowa provided the following are met:

a. *Width.* Not to exceed 10 feet 0 inches.

b. *Length.* Overall combination length must comply with Iowa Code section 321.457.

c. *Height.* Statutory: Not to exceed 13 feet 6 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Speed.* Rescinded IAB 2/7/01, effective 3/14/01.

f. *Roadway width.* At least 24 feet 0 inches.

g. *Limited movement.* Movement shall be solely for the purpose of delivery or transfer from the point of manufacture or assembly to another point of manufacture or assembly within the state or to a point outside the state and shall be on the most direct route necessary for the movement.

511.9(6) Vehicles with divisible loads of hay, straw, stover, or bagged livestock bedding provided the following are not exceeded:

a. *Width.* 12 feet 5 inches.

b. *Length.* Statutory: 75 feet.

c. *Height.* Statutory: 14 feet 6 inches.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Movement is allowed for unlimited distance; routing through the office of vehicle and motor carrier services and city and county jurisdictions is not required.

511.9(7) Necessary trip routes must be obtained from the appropriate city and county jurisdictions.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.8, 321E.10 and 321E.29.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.10(321,321E) Multitrip permits. Multitrip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit shall be for unlimited trips along a specific route between one point of origin and one point of destination. Additional routes will require a new permit. Multitrip permits are issued for the following:

511.10(1) Multitrip permits may be issued for vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* 16 feet.

b. *Length.* 120 feet.

c. *Height.* 15 feet 5 inches.

d. *Weight.* 156,000 pounds total gross weight.

e. *Distance.* On routes specified by the permit-issuing authority.

511.10(2) Multitrip permits may be issued for all movements allowed under the single-trip permit provisions of rule 761—511.12(321,321E) provided the movement is within the size and weight limitations of subrule 511.10(1).

511.10(3) The dimensions listed on the permit are considered maximums. The movement is legal as long as the vehicle and load do not exceed these dimensions and the movement meets all other requirements of Iowa Code chapter 321E and this chapter of rules.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3 and 321E.9A.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.11(321E) Compacted rubbish vehicle permits. All compacted rubbish vehicle permits issued by the department shall be subject to the following:

511.11(1) Permits issued shall be in writing or in an electronic format, shall be carried in the vehicle for which the permit has been issued and shall be available for inspection by any peace officer or authorized agent of any permit-granting authority.

511.11(2) Movements by permit shall be allowed day and night, seven days a week including holidays.

511.11(3) Vehicles traveling under permit shall be registered for the gross weight or combined gross weight of the vehicle and load.

511.11(4) Vehicles under permit must be in compliance with posted bridge and road embargoes and speed limits.

511.11(5) Maximum axle weight allowed on the interstate system shall be 20,000 pounds on a single axle and 34,000 pounds on a tandem axle.

This rule is intended to implement Iowa Code section 321E.30.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.12(321,321E) Single-trip permits. Single-trip permits are issued for indivisible vehicles or indivisible loads for travel when either the dimensions or the weight or both the dimensions and the weight exceed statutory limits. The permit shall be for a specific route between an origin and destination. Single-trip permits are issued for the following:

511.12(1) Vehicles with indivisible loads, including special mobile equipment, mobile homes and factory-built structures, provided the following are not exceeded:

a. *Width.* Limited to the maximum physical limitations and clearances of the roadway and infrastructure along the intended route of travel.

b. *Length.* Limited to the maximum physical limitations and clearances of the roadway along the intended route of travel.

c. *Height.* Limited only to the height of underpasses, bridges, power lines, and other established height restrictions. The carrier shall be required to contact affected public utilities when the height of the vehicle with load exceeds 16 feet 0 inches. At the discretion of the permit-issuing authority, a written verification may be required from the affected utility.

d. *Weight.* See rule 761—511.13(321,321E).

e. *Distance.* Limited at the discretion of the permit-issuing authority. The following factors shall be considered:

Road conditions; road width; traffic volume; weather conditions; and roadside obstructions, including bridges, signs and overhead obstructions.

511.12(2) Reserved.

This rule is intended to implement Iowa Code sections 321.454, 321.456, 321.457, 321.463, 321E.2, 321E.3, 321E.9 and 321E.29.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.13(321,321E) Maximum axle weights and maximum gross weights for vehicles and loads moved under permit.

511.13(1) *Annual and all-systems permits.*

a. For movement under an annual or all-systems permit, the axle weight and combined gross weight shall not exceed the limits found in Iowa Code section 321.463(3).

b. See subrule 511.13(5) for exceptions for special mobile equipment.

511.13(2) *Annual oversize/overweight permits.*

a. For movement under an annual oversize/overweight permit, the gross weight on any axle shall not exceed 20,000 pounds, with a maximum of 156,000 pounds total gross weight.

b. See subrule 511.13(5) for exceptions for special mobile equipment.

511.13(3) *Multitrip permits.*

a. For movement under a multitrip permit, the gross weight on any axle shall not exceed 20,000 pounds with a maximum of 156,000 pounds total gross weight.

b. See subrule 511.13(5) for exceptions for special mobile equipment.

511.13(4) *Single-trip permits.*

a. For movement under a single-trip permit, the gross weight on any axle shall not exceed 20,000 pounds.

b. If the combined gross weight exceeds 100,000 pounds, a single-trip permit may be issued for the movement only if the permit-issuing authority determines that it would not cause undue damage to the road and is in the best interest of the public.

c. Cranes may have a maximum of 24,000 pounds per axle for movement under a single-trip permit. Routes must be reviewed by the permit-issuing authority prior to issuance.

d. See subrule 511.13(5) for exceptions for special mobile equipment.

511.13(5) *Special mobile equipment.* Special mobile equipment may have a gross weight of 36,000 pounds on any single axle equipped with minimum size 26.5-inch by 25-inch flotation pneumatic tires and a maximum gross weight of 20,000 pounds on any single axle equipped with minimum size 18-inch by 25-inch flotation pneumatic tires, provided that the total gross weight of the vehicle or a combination of vehicles does not exceed a maximum of 80,000 pounds for movement under an annual or all-systems permit and 126,000 pounds for movement under a single-trip, multitrip or annual oversize/overweight permit.

For tire sizes and weights allowed between the maximum and minimum indicated, the following formula shall apply: Axle weight = 20,000 pounds + (tire width - 18) × 1,882 pounds.

This rule is intended to implement Iowa Code sections 321.463, 321E.7, 321E.8, 321E.9, 321E.9A and 321E.32.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.14(321,321E) Movement of vehicles with divisible loads exceeding statutory size or weight limits.

511.14(1) Vehicles with divisible loads exceeding statutory size or weight limits may be moved under a single-trip permit if the permit-issuing authority determines that a special or emergency situation warrants its issuance.

511.14(2) At the discretion of the permit-issuing authority, the combined gross weight may exceed the statutory weight, but the axle weights shall be subject to rule 761—511.13(321,321E).

511.14(3) Movement shall be subject to the routes established by the permit-issuing authority.

511.14(4) This rule does not apply to divisible loads of hay, straw, stover or bagged livestock bedding.

This rule is intended to implement Iowa Code sections 321.463 and 321E.29.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.15(321E) Towing units. The towing unit shall be a truck or truck tractor with dual wheels and with a gross vehicle weight rating of at least 10,000 pounds when towing mobile homes or loads exceeding 10,000 pounds.

This rule is intended to implement Iowa Code section 321.457.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.16(321E) Escorting.

511.16(1) *Escort qualification.* An escort shall be a person aged 18 or over who possesses a valid driver's license which allows driving unaccompanied and who carries proof of public liability insurance in the amounts of $100,000/$200,000/$50,000.

511.16(2) *Escorting responsibilities.*

a. The escorting vehicle shall be a mid-size automobile or motor truck with sufficient mobility to be able to assist in an emergency and designed to afford clear and unobstructed vision both front and rear. The escorting vehicle shall not be used to tow a trailer while performing escorting duties. In questionable cases the permit-issuing authority shall determine if a vehicle meets these conditions.

b. The escorting vehicle shall have a flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning. While escorting a permit load, the light shall be mounted on top of the escort vehicle and shall be burning. Additional escort vehicle markings may be approved or required by the permit-issuing authority.

c. An 18-inch by 18-inch red or orange fluorescent flag shall be mounted on each corner of the front bumper of the escort vehicle.

d. The escort shall remain a distance of approximately 300 feet in front or to the rear of the load. However, when traveling within the corporate limits of a city, the escort shall maintain a reasonable and proper distance consistent with existing traffic conditions.

e. A separate escort shall be provided for each load hauled under escort.

f. All traffic laws and provisions of the oversize permit for the load shall be obeyed.

g. The escort shall not assume responsibility for stopping traffic. An on-duty peace officer, as defined in Iowa Code section 321.1, shall be contacted to provide any traffic control needed.

h. Immediately prior to an escorting trip, the escort shall determine that the escorting vehicle is in a safe operational condition and that the dimensions of the vehicle and load are in compliance with the permit issued.

i. Escort fees charged by state and local authorities shall not exceed $250 per day per escort vehicle.

j. A pole used for measuring vertical clearances shall be mounted on the front escort vehicle. The escort shall be required to measure all vertical clearances whenever the height of the permitted vehicle exceeds 14 feet 6 inches up to and including 20 feet.

511.16(3) *Requirements for escorts, flags, signs and lights.* The following chart explains the minimum escort and warning devices required for vehicles operating under permit.

Minimum Warning Devices and Escort Requirements
For Vehicles Operating Under Permit

	Flags/Signs	**Lights**	**Escorts**	
			4-Lane	**2-Lane**
Length				
75′1″ up to and including 85′	yes	not required	not required	not required
Over 85′ up to and including 120′	yes	yes	not required	not required
Over 120′	yes	not required	rear	rear
Projections				
Front: over 25′	not required	yes	not required	not required
Rear: over 4′ up to and including 10′	flags only	not required	not required	not required
Rear: over 10′	flags only	yes	not required	not required
Height				

Over 14′6″ up to and including 20′	yes	not required	front with a height pole	front with a height pole
Weight				
Over 80,000 lbs.	not required	yes	not required	not required
Width				
Over 8′6″ up to 12′0″	yes	not required	not required	not required
Over 12′0″ up to and including 14′6″	yes	not required	rear *	front *
Over 14′6″ up to and including 16′6″	yes	not required	rear *	front
Over 16′6″ up to and including 18′	yes	not required	rear	front

*In lieu of an escort, a carrier can display an amber light or strobe light on the power unit and on the rear extremity of the vehicle or load.

yes = required

Definitions:

Flags - Red or orange fluorescent flags at least 18″ square must be mounted as follows: one flag at each front corner of the towing unit and one flag at each rear corner of the load. In addition, there must be a flag at any additional protrusion in the width of the load.

Signs - A sign reading "Oversize Load" must be used. The sign must be at least 18″ high by 7′ long with a minimum of 10″ black letters, with a 1½″ stroke, on a yellow background, and mounted on the front bumper and on the rear of the load. The rear sign for mobile homes and factory-built structures must be mounted at least 7′ above the highway surface, measuring from the bottom of the sign.

Lights - A flashing or strobe amber light that is visible for at least 500 feet and provides 360° warning must be mounted on the towing unit and be visible from front and rear. More than one light may be necessary.

The permit-issuing authority may require additional escorts when deemed necessary. The signs or warning devices must be removed or covered when the vehicle is within legal dimensions.

This rule is intended to implement Iowa Code sections 321E.14, 321E.24 and 321E.34.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.17(321,321E) Permit violations.

Permit violations are to be reported to the permit-issuing authority by the arresting officer and the permit holder. If a permit holder is found to have willfully violated permit provisions, the office of vehicle and motor carrier services may, after notice and hearing, suspend, modify or revoke the permit privileges of the permit holder consistent with Iowa Code section 321E.20.

This rule is intended to implement Iowa Code sections 321.492, 321E.16 and 321E.20.

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

761—511.18(321) Movement of combination vehicles on economic export corridors.

511.18(1) *Designation of economic export corridors.*

a. The department may in its discretion establish economic export corridors for the transportation of goods or products manufactured in Iowa to or through the state of South Dakota and for the return of unladen semitrailers or unladen full trailers used for the transportation of those goods or products. An economic export corridor shall not include any segment of the interstate system or any part of the national network of highways identified pursuant to 23 CFR Part 658. However, if appropriate, the department may petition the Federal Highway Administration to remove a road or road segment from the national network of highways for the purpose of including it in an economic export corridor.

b. The department may initiate designation of economic export corridors, or a request for economic export corridor designation may be submitted to the department by an interested party. If a

proposed economic export corridor includes any roads or road segments that are under the jurisdiction of a city or a county, a resolution from all relevant local jurisdictions must be submitted to the department indicating their support for economic export corridor designation. The resolution must include a description of the proposed economic export corridor under local jurisdiction.

c. The department shall exercise due regard for the safety of the traveling public and the protection of the highway surfaces and structures when establishing an economic export corridor. Factors to be considered include ability of the proposed economic export corridor to safely accommodate combinations of vehicles described in subrule 511.18(2), taking into account physical configurations and restrictions and traffic demands and capacity, as well as connection to markets that will benefit from the established economic export corridor.

d. The department will post established economic export corridors on the department's Web site.

511.18(2) *Combination vehicles that may be operated on an economic export corridor.*

a. In addition to combinations of vehicles lawful for operation on roads or road segments not designated as an economic export corridor, the following combinations of vehicles may be operated on an economic export corridor designated under subrule 511.18(1) if the combinations of vehicles meet the requirements in paragraph 511.18(2)*"b"*:

(1) A truck tractor-semitrailer-semitrailer converted to a full trailer by use of a dolly equipped with a fifth wheel which is considered a part of the trailer for all purposes, and not a separate unit; or

(2) A truck tractor-semitrailer-full trailer; or

(3) A truck tractor-semitrailer-semitrailer combination, where the semitrailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

b. The combination of vehicles shall meet all of the following requirements:

(1) The length of the combination of vehicles, excluding the length of the truck tractor, shall not exceed 81½ feet.

(2) The length of either semitrailer or full trailer shall not exceed 45 feet.

(3) The weight of the second semitrailer or full trailer shall not exceed the weight of the first semitrailer by more than 3,000 pounds.

(4) The gross weight of the combination of vehicles shall not exceed 80,000 pounds and the combination of vehicles shall not exceed the gross axle weight limits of Iowa Code section 321.463(2).

(5) The load on each semitrailer or full trailer in the combination shall be an indivisible load. For the purpose of issuing permits for height or width under Iowa Code chapter 321E, the combination of vehicles shall be considered an indivisible load so long as the load on each semitrailer or full trailer in the combination remains an indivisible load.

c. The length of the frame extension shall not be included when determining the overall length of the first semitrailer in a truck tractor-semitrailer-semitrailer combination in which the semitrailers are connected by a rigid frame extension including a fifth wheel connection point attached to the rear frame of the first semitrailer.

d. For purposes of this subrule, "full trailer" means as defined in 49 CFR Section 390.5.

This rule is intended to implement Iowa Code section 321.457(2)*"n."*

[**ARC 3193C**, IAB 7/5/17, effective 8/9/17]

[Filed February 5, 1969; amended May 1, 1969, October 14, 1969, April 30, 1970, October 15, 1971, April 15, 1974, December 4, 1974, May 14, 1975; transferred to Department of Transportation, July 1, 1975]
[Filed 5/26/76, Notice 4/5/76—published 6/14/76, effective 7/19/76]
[Filed 9/16/77, Notice 7/13/77—published 10/5/77, effective 11/9/77]
[Filed 9/8/78, Notice 7/26/78—published 10/4/78, effective 11/8/78]
[Filed emergency 6/21/79—published 7/11/79, effective 6/21/79]
[Filed emergency 9/20/79—published 10/17/79, effective 9/20/79]
[Filed 1/28/80, Notice 12/12/79—published 2/20/80, effective 3/26/80]
[Filed emergency 2/14/80 after Notice 12/12/79—published 3/5/80, effective 3/26/80]
[Filed 6/2/81, Notice 4/15/81—published 6/24/81, effective 7/29/81]

[Filed 12/2/81, Notice 9/30/81—published 12/23/81, effective 1/27/82]
[Filed 12/16/82, Notice 10/27/82—published 1/5/83, effective 2/9/83]
[Filed emergency 3/31/83—published 4/27/83, effective 3/31/83]
[Filed 12/11/85, Notice 10/23/85—published 1/1/86, effective 2/5/86]
[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]
[Filed 5/13/87, Notice 3/25/87—published 6/3/87, effective 7/8/87]
[Filed emergency 3/26/92—published 4/15/92, effective 4/29/92]
[Filed 4/8/93, Notice 3/3/93—published 4/28/93, effective 6/2/93][1]
[Filed emergency 7/8/94—published 8/3/94, effective 7/8/94]
[Filed 9/8/94, Notice 8/3/94—published 9/28/94, effective 11/2/94]
[Filed 3/5/97, Notice 1/15/97—published 3/26/97, effective 4/30/97]
[Filed emergency 6/26/97—published 7/16/97, effective 7/1/97]
[Filed 8/27/97, Notice 7/16/97—published 9/24/97, effective 10/29/97]
[Filed 1/16/01, Notice 11/29/00—published 2/7/01, effective 3/14/01]
[Filed 12/19/01, Notice 11/14/01—published 1/23/02, effective 2/27/02]
[Filed 9/11/02, Notice 7/10/02—published 10/2/02, effective 11/6/02]
[Filed 9/14/05, Notice 8/3/05—published 10/12/05, effective 11/16/05]
[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]
[Filed 12/12/07, Notice 11/7/07—published 1/2/08, effective 2/6/08]
[Filed ARC 0136C (Notice ARC 0068C, IAB 4/4/12), IAB 5/30/12, effective 7/4/12]
[Filed ARC 3193C (Notice ARC 3045C, IAB 5/10/17), IAB 7/5/17, effective 8/9/17]

[1] Effective date of 511.2(1), 511.4(1)*"a,"* 511.4(2)*"a"* and *"b,"* 511.5(1), 511.5(6)*"b"*(3), 511.7, 511.8, 511.9(1) to 511.9(5), 511.14(2)*"g"* and *"i,"* 511.14(3)*"e,"* delayed 70 days by the Administrative Rules Review Committee at its meeting held May 12, 1993; delay lifted by this Committee June 8, 1993, effective June 9, 1993.

CHAPTER 512
Reserved

CHAPTER 513
COMPACTED RUBBISH VEHICLE PERMITS
[Prior to 6/3/87, Transportation Department[820]—(07,F) Ch 6]
Rescinded **ARC 3193C**, IAB 7/5/17, effective 8/9/17

CHAPTERS 514 to 519
Reserved

CHAPTER 920
STATE TRANSIT ASSISTANCE

[Prior to 6/3/87, Transportation Department [820]—(09,B)Ch 1]

761—920.1(324A) Statement of policy. State financial assistance to any public transit system shall be restricted to joint projects with the department that hold substantial promise of accomplishing the following goals:

920.1(1) Development, maintenance and improvement of transit services for the general public and for transportation disadvantaged persons.

920.1(2) Protection of the rights of private enterprise public transit providers, especially those providing intercity scheduled services on fixed routes.

920.1(3) Improvement of transit system effectiveness and efficiency.

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—920.2(324A) General information. The department shall post annually the required forms and instructions for applying for state transit assistance to the department's Web site at www.iowadot.gov and notify each public transit system in Iowa of the availability. Requests for assistance and questions about application preparation should be directed to: Office of Public Transit, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870.

[Editorial change: IAC Supplement 2/23/11; **ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—920.3(324A) Definitions. The definitions in Iowa Code section 324A.1 apply to this chapter. In addition:

"Formula assistance" means state transit assistance appropriations minus funds reserved for special projects.

"Joint participation agreement" means a contract between the department and a public transit system for either operations or capital assistance needed for implementation of a transit service project or projects. Each agreement shall include, but not be limited to, a project budget, method of payment, and period of performance.

"Project" means a concerted set of actions that will develop, maintain, or improve one or more elements of the public transit system's service.

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—920.4(324A) Types of projects.

920.4(1) *Formula projects.* A formula project may involve operations assistance, capital assistance, planning, or any combination of the three. These projects are developed, analyzed and ranked through the transit planning process which involves the following steps:

a. Each public transit system shall arrange with the appropriate planning agencies for a review of all projects submitted, shall ensure public participation and discussion, and shall list the projects by priority.

b. Each public transit system shall submit its ranked list of proposed projects to the department.

920.4(2) *Special projects.*

a. Special projects are extraordinary, emergency or innovative in nature, and may include, but are not limited to, the following purposes:

(1) Expanding the scope of planning, managerial, or technical expertise.

(2) Increasing the public's awareness and understanding of transit.

(3) Enhancing the capacity for administration consolidation and service coordination.

(4) Reducing impediments to intramodal or intermodal transfers.

(5) Increasing the cooperation and coordination between private and public sectors.

(6) Developing, demonstrating, or refining a technical, procedural, or mechanical innovation that may be utilized by other public transit systems in Iowa.

(7) Responding to an emergency situation that places an extraordinary and unforeseen strain on the resources of a public transit system.

b. Proposals for special projects may be submitted to the department at any time.
[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—920.5(324A) Standards for projects.

920.5(1) *Requirements for transit system.* A public transit system is eligible for project assistance if the system is in compliance with all of the following criteria:

a. The transit system abides by all applicable state and federal laws and regulations.

b. The transit system maintains primary documentation for all revenues and expenses for a period of at least three years.

c. The transit system maintains the system's policies, routes, schedules, fare structure, and budget in a manner that encourages public review, responsiveness to user concerns, energy conservation, and fiscal solvency.

d. The transit system received departmental approval of the system's plan or schedule for repayment of any loan administered by the department.

e. The transit system accurately reports all services to be supported with project formula assistance and ensures that all services are open to the general public.

920.5(2) *Project conditions.* The department shall obligate state transit assistance for joint projects that meet the following criteria:

a. Each project must be included in the current year of the locally adopted transportation improvement program.

b. Each project shall contain payment criteria, through the joint participation agreement, which are mutually agreed upon by the department and the contracting officer of the transit system.

c. Each special project shall have a preestablished basis for determining success using a specified means of performance management and shall have a detailed budget of the resources available and the assistance necessary for implementation.

d. State assistance for a special project involving capital expense shall not exceed 85 percent of the project's total capital expense. State assistance for a special project involving operating support shall not exceed 80 percent of the project's total operating expense in the first year and 50 percent of the project's total operating expense in the second year.

920.5(3) *Items not eligible for assistance.*

a. Administrative, operations, or capital expenses which are determined by the department to be inconsistent with department policies, public law, officially approved planning and programming documents, or inconsistent with the purpose of improving the effectiveness and quality of transit services.

b. Development of managerial, administrative, or operational systems which duplicate programs made available at no charge to the transit system by the department.

920.5(4) *Determination of system eligibility for formula assistance.*

a. Prior to the beginning of each fiscal year, each state-designated public transit system's formula percentage shall be determined through the process shown in the appendix located at the end of this chapter.

(1) Transit system data used in determining formula percentage is based only on services which are open to the general public and is derived from the last fiscal year for which complete information is available.

(2) The process shown in the appendix establishes the percentage of available state transit assistance funds not reserved for special projects for which each transit system is eligible during the fiscal year.

b. The amount of each system's eligibility for formula assistance from this appropriation shall be determined by multiplying the system's formula percentage by the amount of the appropriation not reserved for special projects.

c. If the dollar amount of state transit assistance is not known until the funds are actually deposited in the state transit assistance account, the amount of each system's eligibility for formula assistance from these funds shall be determined as follows: At the beginning of each month, the system's formula

percentage shall be multiplied by the amount of new funds not reserved for special projects that were deposited in the state transit assistance account during the previous month.

d. A transit system's eligibility for programmed project assistance may be reduced if it is subject to the sanctions outlined in Iowa Code section 324A.5 or 761—Chapter 910.

920.5(5) *Determination of amount reserved for special projects.* Each fiscal year, at least $300,000 will be reserved from state transit assistance appropriations for special projects. Any special project funds not obligated in the previous fiscal year and any funds made available through closeout of previously approved projects may also be reserved for special projects. Special project funds are distributed by the department on a discretionary basis in accordance with subrule 920.4(2).

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—920.6(324A) Processing.

920.6(1) *Review.* The department shall review the proposed projects.

920.6(2) *Program.* Based on available funds and the project priorities established by the transit systems, the department shall prepare a set of funding recommendations.

920.6(3) *Approval and agreement.* Upon approval of the projects by the transportation commission, the department shall prepare a joint participation agreement and send it to each public transit system for execution.

920.6(4) *Advance payment allowed.* Each transit system with a signed joint participation agreement may be paid formula assistance monthly, in advance of project expenditures, if all of the following conditions are met:

a. The transit system included in its application a request for advance allocations as set forth in Iowa Code section 324A.6.

b. The transit system is current on all reporting required by the department.

c. The transit system is current on all scheduled repayments under loan contracts from the department.

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

These rules are intended to implement Iowa Code chapter 324A.

APPENDIX TO
761—920.5(324A)

FP	Formula percentage. The percentage of any state transit assistance appropriation that a public transit system is eligible to receive from the nondiscretionary portion of the appropriation. Determination of a public transit system's formula percentage shall be made using the method diagrammed in this appendix.
FY	Fiscal year. The 12-month period beginning July 1 of one year and ending June 30 of the following year.
LDI	Locally determined income. All transit system revenue dedicated for operations expense during a fiscal year, minus federal operating assistance from the U.S. Department of Transportation and minus all special project operating support and formula assistance funds received from the Iowa Department of Transportation.
OpExp	Operations expense. All eligible transit system expenses related to operating, maintaining, and administering transit operations.
Pass	Passenger. A person boarding a transit vehicle for the purpose of making a trip. A passenger is counted each time that person boards a vehicle for travel to a destination.
RevMi	Revenue miles. Total vehicle miles traveled by revenue vehicles of public transit systems while in revenue service. Excludes miles traveled to and from storage facilities and other deadhead travel.

APPENDIX TO
761—920.5(324A)

FORMULA FOR DETERMINATION OF FORMULA PERCENTAGE

$$\text{Regional System's FP} = .50\,\frac{\text{Regional RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's LDI}}{\text{Sum of LDI for all regions}} + .25\,\frac{\text{Regional RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's Pass to OpExp ratio}}{\text{Sum of Pass to OpExp ratios for all regions}} + .25\,\frac{\text{Regional RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's RevMi to OpExp ratio}}{\text{Sum of RevMi to OpExp ratios for all regions}}$$

$$\text{Urban System's FP} = .50\,\frac{\text{Urban RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's LDI}}{\text{Sum of LDI for all urbans}} + .25\,\frac{\text{Urban RevMi}}{\text{Total State RevMi}} \times \frac{\text{System Pass to OpExp ratio}}{\text{Sum of Pass to OpExp ratios for all urbans}} + .25\,\frac{\text{Urban RevMi}}{\text{Total State RevMi}} \times \frac{\text{System's RevMi to OpExp ratio}}{\text{Sum of RevMi to OpExp ratios for all urbans}}$$

[Filed 9/15/76, Notice 7/26/76—published 10/6/76, effective 11/10/76]
[Filed 2/18/82, Notice 1/6/82—published 3/17/82, effective 4/21/82]
[Filed 4/17/85, Notice 2/27/85—published 5/8/85, effective 6/12/85]
[Filed emergency 12/11/85—published 1/1/86, effective 1/1/86]
[Filed 2/20/86, Notice 1/1/86—published 3/12/86, effective 4/16/86]
[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]
[Filed emergency 6/15/89 after Notice 5/3/89—published 7/12/89, effective 7/1/89]
[Filed 9/25/91, Notice 8/21/91—published 10/16/91, effective 11/20/91]
[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]
[Filed emergency 7/1/92—published 7/22/92, effective 7/27/92]
[Filed 3/25/94, Notice 2/16/94—published 4/13/94, effective 5/18/94]
[Filed 9/8/94, Notice 7/20/94—published 9/28/94, effective 11/2/94]
[Editorial change: IAC Supplement 2/23/11]
[Filed ARC 3194C (Notice ARC 3034C, IAB 4/26/17), IAB 7/5/17, effective 8/9/17]

CHAPTER 921
ADVANCED ALLOCATIONS OF STATE TRANSIT ASSISTANCE FUNDING

[Prior to 6/3/87, Transportation Department [820]—(09,B)Ch 2]

761—921.1(324A) Scope of chapter. This chapter shall apply only to those transit systems eligible for and having or proposing to have a joint participation agreement in force with the department for state transit assistance funding as set forth in 761—Chapter 920. This chapter implements provisions for advance allocations of state transit assistance funding as set forth in Iowa Code section 324A.6(4). The definitions in Iowa Code section 324A.1 apply to this chapter. The requirements for the award of state funds for state transit assistance and subsequent procedures are found in 761—Chapter 920.
[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—921.2(324A) Advance allocations. Advance allocations of state transit assistance are paid prior to the time actual expenditures are incurred. Payment of one-twelfth (or 8.33 percent) of the total joint participation agreement amount is made prior to or during each month, starting on the execution date of the joint participation agreement.
[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—921.3(324A) Application for advance allocations.

921.3(1) Transit systems having or proposing to have a joint participation agreement with the department for state transit assistance funding may make written application for advance allocations of the joint participation agreement amount. The application shall be directed to: Office of Public Transit, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010. Applications are available on the department's Web site at www.iowadot.gov or by telephone at (515)233-7870.

921.3(2) Transit systems applying for state transit assistance funding, pursuant to 761—Chapter 920, may make written application for advance allocations of a proposed or existing joint participation agreement amount as part of the application for state transit assistance.

921.3(3) No application for advance allocation shall be complete without:

a. The name of the transit system.

b. A specific statement of the reasons why an advance allocation is required by the transit system.

c. A statement from the transit system which indicates the specific existing or proposed joint participation agreement from which advance allocations are to be derived.

d. A statement from the transit system which indicates that the contract officer has read these administrative rules and certifies that the contract officer shall comply with them.

e. The signature of the contract officer of the transit system, and the date of the signature.
[Editorial change: IAC Supplement 2/23/11; **ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—921.4(324A) Application approval. The department shall review all applications for advance allocations of state transit assistance. The department shall also approve, disapprove or defer all such applications. Provisions of applications which are approved shall be written into and made a part of the transit system's state transit assistance joint participation agreement, if it is in effect, or written into such joint participation agreement when awarded by the department pursuant to 761—Chapter 920. The transit system shall be so notified of such action. Transit systems whose applications for advance allocations are disapproved or deferred shall be so notified by the department, including the reason(s) for such actions.
[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—921.5(324A) Consideration in determining the approval of advance allocation application. The department shall give consideration to the following items in determining the approval, disapproval or deferment of advance allocation applications:

921.5(1) The justification submitted with the application pursuant to subrule 921.3(3).

921.5(2) Previous experience of the department in dealing with the transit system making application including but not limited to the following:

a. Timeliness of contract and application materials, as assessed by the department.

b. Fiscal management capability of the transit system, as assessed by the department.
[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—921.6 Rescinded, effective April 16, 1986.

761—921.7(324A) Reports, and suspension and termination of allocations.

921.7(1) Transit systems receiving advance allocations shall provide quarterly and end-of-the-year financial and statistical reports to the department in the manner and within the time limits described in the state transit assistance joint participation agreements. These reports shall be made through an online portal furnished to the transit systems by the department.

921.7(2) Failure to file quarterly and end-of-the-year financial and statistical reports by any transit system with the department in the manner and within the time limits described in the state transit assistance joint participation agreement shall be cause for suspension or termination of those provisions of the joint participation agreement, and therefore, suspension or termination of advance allocation payments made by the department. The department shall notify any transit system of such actions.

921.7(3) Payment of eligible joint participation agreement expenses to a transit system that has had advance allocation contract provisions suspended or terminated by the department shall be by the method of reimbursement payments as described in the state transit assistance joint participation agreements.
[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—921.8(324A) Income derived from interest-bearing accounts and investments.

921.8(1) Any transit system that receives advance allocation payments shall deposit these funds in a separately identified interest-bearing account until such time as they are expended on costs incurred by the transit system.

921.8(2) All income derived from interest-bearing accounts and investments shall be credited to the transit system and its transit accounts as a nonoperating or nontransportation revenue.

761—921.9(324A) Joint participation agreement close and audits.

921.9(1) Each transit system receiving advance allocations shall, as part of the end-of-the-year financial and statistical report, calculate the total joint participation agreement amount eligible for payment by the department within the limits stated in the joint participation agreement. This eligible joint participation agreement amount shall be compared to the total amount of the advance allocations for that joint participation agreement. If the advance allocations' total is greater than the eligible joint participation agreement amount, the transit system must repay the department the difference. After verification of these calculations, the department shall issue to the public transit system an invoice for the amount of the required repayment. Failure to make this repayment shall be grounds for:

a. Termination of other transit assistance joint participation agreements with that transit system,

b. Suspension or termination of further advance allocations made on future joint participation agreements,

c. Reduction of department participation in existing or future joint participation agreements, or

d. Reducing future joint participation agreement reimbursement requests of the transit system by an amount not to exceed the unpaid debt owed the department and crediting the outstanding debt of the project being closed out.

921.9(2) The department may institute any such action(s) as stated in subrule 921.9(1) above and shall notify any transit system of such action taken against the transit system.

921.9(3) After the repayment and end-of-the-year financial and statistical reports are submitted, or after the department has instituted any action(s) for failure to do so, the department shall audit the transit system's books, accounts, records and other material and information necessary to determine joint participation agreement compliance. The advance allocations paid to the transit system shall be taken into consideration and made part of the amount to be audited.
[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

These rules are intended to implement Iowa Code chapter 324A.

[Filed emergency 10/26/79—published 11/14/79, effective 10/26/79]

[Filed 2/20/86, Notice 1/1/86—published 3/12/86, effective 4/16/86]
[Filed 5/11/87, Notice 3/11/87—published 6/3/87, effective 7/8/87]
[Filed 1/15/92, Notice 12/11/91—published 2/5/92, effective 3/11/92]
[Filed emergency 7/1/92—published 7/22/92, effective 7/27/92]
[Editorial change: IAC Supplement 2/23/11]
[Filed ARC 3194C (Notice ARC 3034C, IAB 4/26/17), IAB 7/5/17, effective 8/9/17]

CHAPTER 924
PUBLIC TRANSIT INFRASTRUCTURE GRANT PROGRAM

761—924.1(324A) Purpose. The purpose of the public transit infrastructure grant program is to provide funding for improvement of the vertical infrastructure of Iowa's designated public transit systems.

761—924.2(324A) Definitions. The following definitions shall apply to this chapter:

"Public transit system" means one of the regional transit systems or urban transit systems designated under Iowa Code section 324A.1.

"Vertical infrastructure" means the same as defined in Iowa Code section 8.57(5).

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—924.3(324A) Information and forms. Information, instructions, and application forms are available from the Office of Public Transit, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010; telephone (515)233-7870; or the department's Web site at www.iowadot.gov.

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—924.4 Reserved.

761—924.5(324A) Applicant eligibility. Rescinded **ARC 3194C**, IAB 7/5/17, effective 8/9/17.

761—924.6(324A) Project eligibility. Projects may be considered for funding only if:

924.6(1) The project has been included in a locally approved transportation improvement program and in the statewide transportation improvement program.

924.6(2) Local match for the project is currently available.

924.6(3) The project is capable of being substantially completed within 18 months of project selection.

761—924.7(324A) Eligible project activities. Activities that are eligible for reimbursement include, but are not limited to, the following:

924.7(1) Construction, expansion, or renovation of facilities for administration of public transit operations, including any associated design, land acquisition, grading and foundation work.

924.7(2) Construction, expansion, or renovation of facilities for servicing, maintenance or storage of public transit vehicles, including any associated design, land acquisition, grading and foundation work.

924.7(3) Construction, expansion, or renovation of transit vehicle fueling facilities, including any associated design, land acquisition, grading and foundation work.

924.7(4) Construction, expansion, or renovation of passenger waiting facilities, including any associated design, land acquisition, grading and foundation work.

924.7(5) Relocating an existing administrative or maintenance facility, if necessary to correct violations of safety or design standards. Such project may include any associated design, land acquisition, grading and foundation work.

761—924.8(324A) Ineligible project activities. A transit facility may be incorporated into a larger project. Examples might include, but are not limited to, an intermodal facility, a headquarters for the umbrella organization sponsoring the transit program, or a public works facility. If this is the case, those costs attributable to the nontransit elements of the larger project shall not be eligible under this program.

761—924.9 Reserved.

761—924.10(324A) Funding.

924.10(1) Program funds may reimburse up to 80 percent of transit-related project costs.

924.10(2) At least 20 percent of transit-related project costs must be provided from local sources by the sponsoring transit system in cash or value of real property.

924.10(3) Assistance from the public transit infrastructure grant program, when combined with federal or other state resources, may not exceed 80 percent of the project's transit-related costs.

761—924.11(324A) Project applications.

924.11(1) Project applications shall be submitted to the department.

924.11(2) Each application shall contain:

a. General information, including the transit system name, contact person, mailing address, E-mail address, telephone number, and fax number.

b. A project data sheet. The data sheet shall include the following:

(1) A brief description of the project and its purpose, project justification and anticipated benefits to the transit program.

(2) Cost information including total project cost and an itemized breakdown of project components (including transit vs. nontransit costs).

(3) The proposed implementation schedule.

(4) A statement of the applicant's ability to complete the project.

(5) A sketch of the project.

c. Documentation of project justification.

d. A resolution from the governing body of the sponsoring transit system endorsing the project and authorizing the necessary local funding match.

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—924.12 and **924.13** Reserved.

761—924.14(324A) Project priorities. The transportation commission shall consider the following in project selection:

924.14(1) Benefits of project to the transit program in terms of:

a. Enhancement of the life of the transit vehicle fleet.

b. Enhancement to transit services.

c. Increased ridership.

924.14(2) Readiness to proceed.

924.14(3) Feasibility of timely completion of the proposed project.

924.14(4) Ability of the project to leverage other funds.

761—924.15(324A) Review and approval. Department staff shall review project applications and shall submit recommendations to the transportation commission. The transportation commission is responsible for approving the projects to be funded.

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

761—924.16(324A) Project agreement, administration and ownership.

924.16(1) *Agreement.* After a project has been approved, the department shall enter into an agreement with the transit system sponsoring the project.

924.16(2) *Payments.* Payments to the transit system sponsor for eligible project costs shall be made on a cost reimbursement basis.

924.16(3) *Ownership.* The transit system must retain ownership of the new, renovated or repaired structure or facility for its useful life. If the structure or facility is transferred to a subcontracted entity or is sold before the useful life has expired, the transit system must repay the prorated state interest to the department.

[**ARC 3194C**, IAB 7/5/17, effective 8/9/17]

These rules are intended to implement Iowa Code sections 8.57, 324A.1 and 324A.6A.

[Filed 12/13/06, Notice 11/8/06—published 1/3/07, effective 2/7/07]

[Filed ARC 3194C (Notice ARC 3034C, IAB 4/26/17), IAB 7/5/17, effective 8/9/17]