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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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

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Replace Chapter 4

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Replace Chapter 2
Replace Chapter 3 with Reserved Chapter 3

Human Services Department[441]

Replace Analysis
Replace Chapter 75
Replace Chapters 77 to 79
Replace Chapters 82 and 83
Replace Chapter 88
Replace Chapter 92

Environmental Protection Commission[567]

Replace Analysis
Replace Chapters 68 and 69

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Replace Chapter 106
Replace Chapter 108

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Replace Analysis
Replace Chapter 25
Replace Reserved Chapters 123 and 124 with Chapters 123 and 124

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Created within the Department of Commerce by 1986 Iowa Acts, Senate File 2175.
Formerly Beer and Liquor Control Department[150]

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CHAPTER 4
LIQUOR LICENSES—BEER PERMITS—WINE PERMITS

[Ch 4, IAC 7/1/75 rescinded 3/7/79; see Chs 4,5]
[Prior to 10/8/86, Beer and Liquor Control Department[150]]

185—4.1(123) Definitions.

4.1(1) “*Act*” means the alcoholic beverage control Act.

4.1(2) “*Division*” means the alcoholic beverages division of the department of commerce.

4.1(3) to 4.1(5) Rescinded IAB 5/15/91, effective 6/19/91.

4.1(6) “*Administrator*” means the chief administrative officer of the alcoholic beverages division or a designee.

4.1(7) “*Beverages*” as used in Iowa Code section 123.129 does not include alcoholic liquor, wine, or beer as defined in Iowa Code sections 123.3(5), 123.3(7), and 123.3(37).

This rule is intended to implement Iowa Code sections 123.3 and 123.4.

185—4.2(123) General requirements. All applicants for liquor control licenses, wine permits, or beer permits shall comply with the following requirements, where applicable, prior to receiving a liquor license, wine permit, or beer permit.

4.2(1) *Cleanliness of premises.* The interior and exterior of all licensed premises shall be kept clean, free of litter or rubbish, painted and in good repair. Licensees and permittees shall at all times keep and maintain their respective premises in compliance with the laws, orders, ordinances and rules of the state, county and city health and fire departments and the Iowa department of inspections and appeals.

4.2(2) *Toilet facilities.* All licensees and permittees who mix, serve, or sell alcoholic liquor, wine, or beer for consumption on the licensed premises shall provide for their patrons adequate, conveniently located separate indoor or outdoor toilet facilities for men and women, which shall conform to county, city, and department of inspections and appeals’ rules and regulations. In case of outdoor facilities, they shall be approved by the department of inspections and appeals and the local approving authority where the licensed premises is located.

4.2(3) *Water.* All licensed establishments shall be equipped with hot and cold running water from a source approved by an authorized health department.

4.2(4) *Financial standing and reputation.* A local authority or the administrator may consider an applicant’s financial standing and good reputation in addition to the other requirements and conditions for obtaining a liquor control license, wine or beer permit, or certificate of compliance, and the local authority or the administrator shall disapprove or deny an application for a liquor control license, wine or beer permit, or certificate of compliance if the applicant fails to demonstrate that the applicant complies with the lawful requirements and conditions for holding the license, permit or certificate of compliance.

a. In evaluating an applicant’s “financial standing,” the local authority or the administrator may consider the following: An applicant’s “financial standing” may include, but is not limited to, verified source(s) of financial support and adequate operating capital for the applicant’s proposed establishment, a record of prompt payment of local or state taxes due, a record of prompt payment to the local authority of fees or charges made by a local authority for municipal utilities or other municipal services incurred in conjunction with the proposed establishment, and a record of prompt payment or satisfaction of administrative penalties imposed pursuant to Iowa Code chapter 123.

b. In evaluating an applicant’s “good reputation,” the local authority or the administrator may consider such factors as, but not limited to, the following: pattern or practice of sales of alcoholic beverages to 19- and 20-year-old persons for which the licensee or permittee, the licensee’s or permittee’s agents or employees, have pled or have been found guilty, pattern and practice by the licensee or permittee, or the licensee’s or permittee’s agents or employees, of violating alcoholic beverages laws and regulations for which corrective action has been taken since the previous license or permit was issued, sales to intoxicated persons, licensee or permittee convictions for violations of laws relating to operating a motor vehicle while under the influence of drugs or alcohol, the recency

of convictions under laws relating to operating a motor vehicle while under the influence of drugs or alcohol, licensee or permittee misdemeanor convictions, the recency of the misdemeanor convictions.

This rule is intended to implement Iowa Code sections 123.3(11), 123.21(11) and 123.30.

185—4.3(123) Local ordinances permitted. The foregoing rules shall in no way be construed as to prevent any county, city or town from adopting ordinances or regulations, which are more restrictive, governing licensed establishments within their jurisdiction.

This rule is intended to implement Iowa Code section 123.39.

185—4.4(123) Licensed premises. The following criteria must be met before a “place” (as used in Iowa Code section 123.3(20)) may be licensed as a “place susceptible of precise description satisfactory to the administrator.”

4.4(1) The “place” must be owned by or under the control of the prospective licensee.

4.4(2) The “place” must be solely within the jurisdiction of one local approving authority.

4.4(3) The “place” must be described by a sketch of the “premise” as defined in Iowa Code section 123.3(20) and showing the boundaries of the proposed “place”; showing the locations of selling/serving areas within the confines of the “place”; all entrances and exits; and indicating the measurements of the “place,” and distances between selling/serving areas.

4.4(4) The “place” must satisfy the health, safety, fire and seating requirements of the division, local authorities and Iowa department of agriculture and land stewardship.

This rule is intended to implement Iowa Code sections 123.3(20) and 123.4.

185—4.5(123) Mixed drinks or cocktails not for immediate consumption. An on-premises liquor control licensee may mix, store, and allow the consumption of mixed drinks or cocktails which are not for immediate consumption, subject to the requirements and restrictions provided in 2012 Iowa Acts, House File 2465, section 22, and this rule.

4.5(1) Definitions.

a. Immediate consumption. For purposes of Iowa Code section 123.49(2) “d” as amended by 2012 Iowa Acts, House File 2465, section 22, and this rule, “immediate consumption” is defined as the compounding and fulfillment of a mixed drink or cocktail order upon receipt of the order for the mixed drink or cocktail.

b. Mixed drink or cocktail. A mixed drink or cocktail is a beverage composed in whole or in part of alcoholic liquors, combined with other alcoholic beverages or nonalcoholic beverages or ingredients including but not limited to ice, water, soft drinks, or flavorings.

4.5(2) Location. Mixed drinks or cocktails which are not for immediate consumption shall be mixed, stored, and consumed on the liquor control licensed premises. Mixed drinks or cocktails shall not be removed from the licensed premises.

4.5(3) Quantity. A mixed drink or cocktail which is not for immediate consumption shall be mixed and stored in, and dispensed from, a labeled container in a quantity not to exceed three gallons.

4.5(4) Container. A mixed drink or cocktail which is not for immediate consumption shall at all times be in a container compliant with applicable state and federal food safety statutes and regulations.

a. The mixed drink or cocktail shall be mixed and remain stored in the same container.

b. The mixed drink or cocktail shall be removed from the stored container for one of the following dispensing purposes:

(1) To compound and fulfill a mixed drink or cocktail order upon receipt of the order for the mixed drink or cocktail.

(2) For transfer into a pourable container. The pourable container shall have affixed a label compliant with subrule 4.5(5) displaying label information identical to that on the container from which the contents were poured. The expiration date and time shall not be extended by the transfer of product to a pourable container.

c. The mixed drink or cocktail may be strained into another container when each of the following conditions is met:

(1) The mixed drink or cocktail is returned without delay to the labeled container from which it was strained.

(2) The container and process are compliant with applicable state and federal food safety statutes and regulations.

d. An original package of alcoholic liquor as purchased from the division or an original package of wine shall not be used to mix, store, or dispense a mixed drink or cocktail, pursuant to Iowa Code section 123.49(2) “*d*” as amended by 2012 Iowa Acts, House File 2465, section 22, and section 123.49(2) “*e*.”

e. The mixed drink or cocktail shall not be mixed, stored, or dispensed from a container bearing an alcoholic beverage name brand.

4.5(5) Label. A label shall be placed on a container when the contents of the mixed drink or cocktail are placed into the empty container.

a. Contents are defined in subrule 4.5(6).

b. The label shall be subject to the following requirements and restrictions:

(1) The label shall adhere to the container for the duration of the 72 hours as set forth in 2012 Iowa Acts, House File 2465, section 22, and in subrule 4.5(7).

(2) The label shall be affixed to the container in a conspicuous place.

(3) The label shall legibly identify the month, day, and year the contents are placed into the empty container.

(4) The label shall legibly identify the time the contents were placed into the empty container. The time shall be reported to the minute utilizing the 12-hour clock, and include either the ante meridian (AM) or post meridian (PM) part of time.

(5) The label shall legibly identify the month, day, and year the contents expire.

(6) The label shall legibly identify the time the contents expire. The time shall be reported in the same manner as reported in subparagraph 4.5(5) “*b*”(4).

(7) The label shall legibly specify the title of the recipe used for the contents of the container.

(8) The label shall legibly identify the person who prepared the contents of the container.

(9) The label shall legibly identify the size of the batch within the container and be conspicuously marked with the words “CONTAINS ALCOHOL.”

(10) The label shall be removed from the container only after the entire contents have been consumed or destroyed and disposed of in accordance with applicable law.

(11) A removed label shall not be reapplied to a container.

(12) A new label, subject to the requirements and restrictions of paragraph 4.5(5) “*b*,” shall be affixed to a container that is being reused for a mixed drink or cocktail which is not for immediate consumption.

c. A licensee may access a label template on the Web site of the division located at www.IowaABD.com.

4.5(6) Contents. Contents include alcoholic beverages, nonalcoholic ingredients, or combination thereof, which are not for immediate consumption.

a. A licensee is limited to utilizing alcoholic beverages in the mixed drink or cocktail which are authorized by the license.

b. A licensee shall utilize alcoholic beverages in the mixed drink or cocktail which are obtained as prescribed by Iowa Code chapter 123.

c. The contents of the mixed drink or cocktail shall not include hallucinogenic substances, added caffeine or added stimulants including but not limited to guarana, ginseng, and taurine, or a controlled substance as defined in Iowa Code section 124.401.

4.5(7) Disposal.

a. Any mixed drink or cocktail, or portion thereof, not consumed within 72 hours of the contents being placed into the empty container shall be destroyed and disposed of in accordance with applicable law.

b. An expired mixed drink or cocktail which is not for immediate consumption shall not be:

(1) Added to an empty container and relabeled; or

(2) Added to another mixed drink or cocktail which is not for immediate consumption.

4.5(8) Records. A licensee shall maintain accurate and legible records for each prepared batch of mixed drinks or cocktails which is not for immediate consumption.

a. Records shall contain:

- (1) The month, day, and year the contents are placed into the empty container.
- (2) The time the contents are placed into the empty container. The time shall be reported in the same manner as reported in subparagraph 4.5(5) "b"(4).
- (3) Each alcoholic beverage, including the brand and the amount, placed in the container. The amount of each alcoholic beverage shall be reported utilizing the metric system.
- (4) Each nonalcoholic ingredient placed in the container.
- (5) The recipe title and directions for preparing the contents of the container.
- (6) The size of the batch.
- (7) The identity of the person who prepared the contents of the container.
- (8) The month, day, and year the contents of the container are destroyed and disposed of or entirely consumed.
- (9) The time the contents of the container are destroyed and disposed of or entirely consumed. The time shall be reported in the same manner as reported in subparagraph 4.5(5) "b"(4).
- (10) The method of destruction and disposal or shall specify the entire contents were consumed.
- (11) The identity of the person who destroyed and disposed of the contents, if not consumed.

b. A licensee may access record-keeping forms on the Web site of the division located at www.IowaABD.com, by sending a request by fax to (515)281-7375, or by sending a request by mail to Alcoholic Beverages Division, 1918 SE Hulsizer Road, Ankeny, Iowa 50021.

c. Records shall be maintained on the licensed premises for a period of three years and open to inspection pursuant to Iowa Code section 123.30(1).

4.5(9) Dispensing machines.

a. Machine without alcoholic beverages. Nothing in this rule prohibits a licensee from operating a machine to premix and dispense frozen or iced mixed drinks or cocktails, provided that alcoholic beverages are added to the mixed drink or cocktail after being dispensed from the machine upon receipt of an order for the mixed drink or cocktail. The machine shall comply with all applicable state and federal food safety statutes and regulations.

b. Machine with alcoholic beverages. A dispensing machine which contains a mixed drink or cocktail with alcoholic beverages is subject to the requirements and restrictions of this rule.

4.5(10) Food safety compliance. A licensee who mixes, stores, and allows the consumption of mixed drinks or cocktails which are not for immediate consumption shall comply with all applicable state and federal food safety statutes and regulations.

4.5(11) Federal alcohol compliance. A licensee who mixes, stores, and allows the consumption of mixed drinks or cocktails which are not for immediate consumption shall comply with all applicable federal statutes and regulations. Prohibitions include but are not limited to processing with non-tax-paid alcoholic liquor, aging alcoholic liquor in barrels, heating alcoholic liquor, bottling alcoholic liquor, and refilling alcoholic liquor or wine bottles.

4.5(12) Violations. Failure to comply with the requirements and restrictions of this rule shall subject the licensee to the penalty provisions of Iowa Code section 123.39.

This rule is intended to implement Iowa Code subsection 123.49(2) as amended by 2012 Iowa Acts, House File 2465, section 22.

[ARC 0204C, IAB 7/11/12, effective 7/1/12]

185—4.6(123) Gross receipts from goods and services. Rescinded IAB 5/15/91, effective 6/19/91.

185—4.7(123) Improper conduct.

4.7(1) Illegality on premises. No licensee, permittee, their agent or employee, shall engage in any illegal occupation or illegal act on the licensed premise.

4.7(2) Cooperation with law enforcement officers. No licensee, permittee, their agent or employee, shall refuse, fail or neglect to cooperate with any law enforcement officer in the performance of such officer's duties to enforce the provisions of the Act.

4.7(3) Illegal activities. No licensee, permittee, their agent or employee, shall knowingly allow in or upon the licensed premises any conduct as defined in Iowa Code sections 725.1, 725.2, 725.3, 728.2, 728.3 and 728.5.

4.7(4) Frequenting premises. No licensee, permittee, their agent or employee, shall knowingly permit the licensed premises to be frequented by, or become the meeting place, hangout or rendezvous for known pimps, panhandlers or prostitutes, or those who are known to engage in the use, sale or distribution of narcotics, or in any other illegal occupation or business.

4.7(5) Prohibited interest in business of licensee. Rescinded IAB 5/15/91, effective 6/19/91.

4.7(6) No licensee, permittee, its agents or employees, shall allow any filled, partially filled, or empty liquor glasses or liquor bottles, including miniature liquor bottles during the holiday season, to be taken off the licensed premises. However, unopened and opened containers and glasses of beer may be allowed to be taken off the licensed premises. A Class "E" liquor control licensee, its agents or employees, shall not permit other liquor control licensees or consumers to remove partially filled, empty, open or unsealed containers of alcoholic liquor from the Class "E" licensed premises.

4.7(7) Identifying markers. A licensee shall not keep on the licensed premises nor use for resale alcoholic liquor which does not bear identifying markers as prescribed by the administrator of this division. Identifying markers shall demonstrate that the alcoholic liquor was lawfully purchased from this division.

4.7(8) A licensee or permittee, or an agent or employee of a licensee or permittee, who sells, gives or otherwise supplies alcoholic liquor, wine or beer to a person 19 or 20 years old does not subject the license or permit to suspension or revocation. The division or the local authority shall not impose any administrative sanction, including license suspension or revocation, upon a licensee or permittee who is convicted of a violation of Iowa Code section 123.47A, nor shall administrative proceedings pursuant to Iowa Code chapter 17A and Iowa Code section 123.39 be commenced against a licensee or permittee for a violation of Iowa Code section 123.47A.

4.7(9) The holder of a Class "E" liquor control license shall sell alcoholic liquor in original, sealed and unopened containers only for off-premises consumption.

This rule is intended to implement Iowa Code subsection 123.49(2).

185—4.8(123) Violation by agent, servant or employee. Any violation of the Act or the rules of the division by any employee, agent or servant of a licensee or permittee shall be deemed to be the act of the licensee or permittee and shall subject the license or permit of said licensee or permittee to suspension or revocation.

This rule is intended to implement Iowa Code sections 123.4 and 123.49(2).

185—4.9(123) Gambling evidence. The intentional possession or willful keeping of any gambling device, machine or apparatus as defined in Iowa Code section 99A.1 upon the premises of any establishment licensed by the division shall be prima facie evidence of a violation of Iowa Code section 123.49(2) "a" and subject the license of said licensee or permittee to suspension or revocation.

This rule is intended to implement Iowa Code sections 123.4 and 123.49.

185—4.10(123) Suppliers interest. Rescinded IAB 5/15/91, effective 6/19/91.

185—4.11 Reserved.

185—4.12(123) Display of license, permit, or signs. All licenses, permits or signs issued by the division shall be prominently displayed in full view on the licensed premises.

This rule is intended to implement Iowa Code sections 123.4 and 123.30.

185—4.13(123) Outdoor service. Any licensee or permittee having an outdoor, contiguous, discernible area on the same property on which their licensed establishment is located may serve the type of alcoholic liquor or beer permitted by the license or permit in the outdoor area. After a licensee or permittee satisfies the requirements of this rule, they may serve and sell beer or liquor in both their indoor licensed establishment and in their outdoor area at the same time because an outdoor area is merely an extension of their licensed premise and is not a transfer of their license. A licensee or permittee, prior to serving in the outdoor area, must file with this division:

1. A new diagram showing the discernible outdoor area.
2. A letter from licensee or permittee telling what dates the outdoor area will be used.
3. A letter from local authority approving the outdoor area.
4. A letter from the insurance and bonding companies acknowledging that the outdoor area is covered by the dramshop insurance policy and the bond.

This rule is intended to implement Iowa Code sections 123.3(20), 123.4 and 123.38.

185—4.14(123) Revocation or suspension by local authority. When the local authority revokes or suspends a beer permit, wine permit, or liquor control license, they shall notify the division in written form stating the reasons for the revocation or suspension and in the case of a suspension, the length of time of the suspension.

This rule is intended to implement Iowa Code sections 123.4 and 123.39.

185—4.15(123) Suspension of liquor control license, wine permit, or beer permit. At the time of the suspension of any license, wine permit, or beer permit by the division, there shall be placed, in a conspicuous place in the front door or window of the licensed establishment, a placard furnished by the division showing that the license or permit of that establishment has been suspended by the division and such placard shall also show the number of days and reason for the suspension. No licensee or permittee shall remove, alter, obscure or destroy said placard without the express written approval of the division.

This rule is intended to implement Iowa Code sections 123.4 and 123.39.

185—4.16(123) Cancellation of beer permits—refunds. A beer permittee, or the executor or administrator, may voluntarily surrender such permit to the division or to the local authority. When so surrendered to the division, the division will notify the local authority; state whether there is a complaint on file in the division office; and inquire if there are any complaints filed locally charging such permittee with violation of the laws that would make the permittee ineligible for a refund. When the permit is surrendered to the local authority, the local authority shall notify the division and inquire if there is a complaint on file with the division that would make the permittee ineligible for a refund. The local authority by itself, in the case of retail beer permits, shall make the refund on a quarterly use basis starting from the effective date of the permit. The local authority will complete, and send to the division, a cancellation certificate. The certificate is to be furnished by the division. The permit is to be attached to the cancellation certificate, if at all possible. The division must have all cancellations reported to them.

This rule is intended to implement Iowa Code sections 123.4 and 123.38.

185—4.17(123) Prohibited storage of alcoholic beverages and wine. No licensee shall permit alcoholic beverages and wine, purchased under authority of a retail license or retail permit, to be kept or stored upon any premises other than those licensed. However, under special circumstances, the administrator may authorize the storage of alcoholic beverages and wine on premises other than those covered by the license or permit. The administrator may allow Class “D” liquor control licensees to store alcoholic liquor and wine in a bonded warehouse to be used for consumption in Iowa, under the authority of a Class “D” liquor control license.

This rule is intended to implement Iowa Code sections 123.4 and 123.21(11).

185—4.18(123) Transfer of license or permit to another location. A licensee or permittee cannot transfer to anyone else the right to use the liquor license, wine permit, or beer permit of the licensee or

permittee; the right of transfer is merely an opportunity for a licensee or permittee to use the licensee's or permittee's liquor license, wine permit, or beer permit at a different location. A liquor license, wine permit, or a beer permit may only be transferred within the boundaries of the local authority which approved the license or permit.

4.18(1) *Permanent transfers.* A person may obtain an application for a permanent transfer from the local authority or the division. The application must be approved by the local authority and sent to the division prior to the transfer. An endorsement from the insurance company holding the dramshop policy listing the new address must be sent to the division prior to the transfer. When the above requirements are met, the division shall issue an amended license or permit showing the new permanent address.

4.18(2) *Temporary transfers.* If the transfer of a license or permit is for the purpose of accommodating a special event or circumstance temporary in nature, the minimum time of transfer is hereby set at 24 hours and transfer time shall not exceed seven days. A letter from the local authority granting the temporary transfer must be sent to the division. The insurance company holding the dramshop policy must be notified of any change of address.

This rule is intended to implement Iowa Code sections 123.4 and 123.38.

185—4.19(123) Execution and levy on alcoholic liquor, wine, and beer. Judgments or orders requiring the payment of money or the delivery of the possession of property may be enforced against liquor control licensees and beer and wine permittees by execution pursuant to the provisions of Iowa Code chapter 626, entitled "Executions."

4.19(1) A secured party as defined in Iowa Code section 554.9105(1) "m" may take possession of and dispose of a liquor control licensee's or permittee's alcoholic liquor, wine, and beer in which the secured party has a security interest in such collateral pursuant to the provisions of Iowa Code chapter 554. The secured party may operate under the liquor control license or permit of its debtor as defined in Iowa Code section 554.9105(1) "d" for the purpose of disposing of the alcoholic liquor, wine, and beer. However, if the debtor is a Class "E" liquor control licensee, the secured party may not purchase alcoholic liquor from the division to continue to operate its debtor's business. A secured party operating under the liquor control license or permit of its debtor shall dispose of the alcoholic liquor, wine, and beer by sale only to persons authorized under Iowa Code chapter 123 to purchase alcoholic liquor, wine, and beer from the debtor. When a secured party takes possession of a liquor control licensee's or permittee's alcoholic liquor, wine, and beer, the secured party shall notify the division in writing of such action. A secured party shall further inform the division of the manner in which it intends to dispose of the alcoholic liquor, wine, and beer and shall state the reasonable length of time in which it intends to operate under the liquor control license or permit of its debtor. The secured party shall notify the division in writing when the disposition of its collateral has been completed, and the secured party shall cease operating under the liquor control license or permit of its debtor.

4.19(2) A sheriff or other officer acting pursuant to Iowa Code chapter 626 may take possession of a liquor control licensee's or permittee's alcoholic liquor, wine, and beer and may dispose of such inventory according to the provisions of Iowa Code chapter 626; however, the sheriff or other officer must sell the alcoholic liquor, wine and beer only to those persons authorized by Iowa Code chapter 123 to purchase alcoholic liquor, wine, and beer from the liquor control licensee whose inventory is subject to the execution and levy. The sheriff or other officer shall notify the division in writing at the time the sheriff or officer takes possession of a liquor control licensee's or permittee's alcoholic liquor, wine, and beer and shall further notify the division of the time and place of the sale of such property.

This rule is intended to implement Iowa Code sections 123.4, 123.21(3), and 123.38.

185—4.20(123) Liquor store checks accepted. The Iowa state liquor stores and the division may accept checks from holders of a retail liquor control license, including a Class "E" licensee, under the following conditions:

1. The check must be either the personal check of the licensee or the business check of the licensee. The business check must be the named establishment on the license and cannot be a check on another business owned or operated by the licensee.

2. The check must be signed by the licensee. (For all holders of liquor control licenses this is interpreted as those persons whose authorized signatures are on file with the bank for the licensee's account). However, this does not preclude an agent of the licensee from presenting a check signed by the licensee in the normal transaction of buying liquor.

3. Traveler's checks and bank drafts, signed by the licensee, will be accepted.

4. Personal checks or traveler's checks may be accepted as payment for purchases in state liquor stores. Second party checks shall not be accepted as payment for purchases in state liquor stores. Vendors shall follow the policy established by the administrator of the division for accepting personal checks and traveler's checks for the purchase of alcoholic beverages.

4.20(1) If a licensee presents this division with a check which is subsequently dishonored by the licensee's bank, the administrator of this division shall cause a written notice of nonpayment and penalty to be served upon the licensee. If the licensee fails to satisfy the obligation within ten days after service of the notice, the administrator or designee shall hold a hearing as in other contested cases pursuant to Iowa Code chapter 17A to determine whether or not the licensee failed to satisfy the obligation within ten days after service of the notice of nonpayment and penalty. If the administrator determines that the licensee has failed to satisfy the obligation, after notice and an opportunity to be heard, the administrator shall suspend the licensee's liquor control license for a period of not less than 3 and not more than 30 days.

4.20(2) A retail liquor establishment which tenders the division one insufficient funds check for the purchase of alcoholic liquor will lose its check-writing privilege for 90 days from the date the establishment pays the division even though the division does not suspend the liquor license because the establishment paid the division within the 10-day demand period. A retail liquor establishment which tenders the division more than one insufficient funds check for the purchase of alcoholic liquor will lose its check-writing privilege for 180 days from the date the establishment pays the division even though the division does not suspend the liquor license because the establishment paid the division within the 10-day demand period.

During the period that a licensee may not tender checks to the state liquor stores or this division in payment for alcoholic liquor, state liquor stores and this division may accept from the licensee: cash, money order payable to the division for the amount of the purchase, bank cashier's check signed by a bank official and made payable to the division for the amount of the purchase, or the licensee's personal or business check made payable to the division for the amount of the purchase which has been certified by the bank on which the check is drawn.

4.20(3) The division may collect from the licensee a \$10 fee for each dishonored check tendered to the division by a licensee for the purchase of alcoholic beverages.

4.20(4) The division may accept from the general public for alcoholic beverages traveler's checks issued in a foreign country if payment is in U.S. dollars.

4.20(5) The division may require, at the discretion of the administrator, that a licensee submit a letter of credit in a reasonable amount to be determined by the administrator for future purchases of alcoholic liquor from the division, when a licensee tenders to the division a check which is subsequently dishonored by the bank on which the check is drawn if the licensee fails to satisfy the obligation within ten days after service of notice of nonpayment and penalty.

This rule is intended to implement Iowa Code sections 123.4 and 123.24.

185—4.21(123) Where retailers must purchase wine. Retail licensees and retail permittees must purchase their wine from either a wine wholesaler or a wine and beer wholesaler. Retail licensees and retail permittees cannot buy wine from other retailers.

This rule is intended to implement Iowa Code subsections 123.30(3) and 123.178(3).

185—4.22(123) Liquor on licensed premises. Holders of liquor control licenses must purchase their liquor supplies from state liquor stores.

4.22(1) Exception to the above requirement. "Bona fide conventions or meetings" may bring their own legal liquor onto licensed premises under the following conditions:

a. “Bona fide conventions or meetings” shall be construed to mean an identifiable body of persons gathered together in furtherance of a specific common purpose or cause, whether political, fraternal, or business, including but not limited to structured club meetings and conventions, professional association functions, employer-employee gatherings and political dinners. Neither the mere purchase nor consumption of liquor nor the purchase of an admission ticket shall be deemed to create a specific common purpose or cause.

b. Liquor may be brought onto the licensed premises at a bona fide convention or meeting by either the sponsoring entity or the individuals comprising that entity.

c. Consumption or dispensation of liquor brought onto the licensed premises by a bona fide convention or meeting must be confined to the meeting place or convention rooms within the licensed premises.

d. The liquor must be served to the delegates or guests without cost.

e. At the completion of the convention or meeting, all liquor brought onto the licensed premises by the members of the convention or meeting must be removed from the licensed premises by those members.

f. All other laws and rules governing the license shall apply to dispensing and consumption of liquor at bona fide conventions or meetings, including hours for consumption and Sunday sales.

4.22(2) Reserved.

This rule is intended to implement Iowa Code sections 123.30, 123.46, and 123.95.

185—4.23(123) Liquor on unlicensed places. Liquor may be kept and consumed but not sold on unlicensed places under the following conditions:

4.23(1) Liquor may be kept and consumed in a private home at any time.

4.23(2) Liquor may be kept and consumed, by the guests or residents, in the residential or sleeping quarters of a hotel or motel at any time. This is considered as an extension of the private home.

4.23(3) Liquor may be consumed at a private social gathering in a private place at any time.

4.23(4) A private place is a location which meets all of the following criteria:

a. One to which the general public does not have access at the time the liquor is kept, dispensed or consumed; one at which the attendees are limited to the bona fide social hosts and invited guests.

b. One which is not of a commercial nature at the time the liquor is consumed or dispensed at the location.

c. One where goods or services are neither sold nor purchased at the time the liquor is consumed or dispensed at the location.

d. One where the use of the location was obtained without charges or rent or any other thing of value was exchanged for its use.

e. One which is not a licensed premises.

f. One where no admission fees or other kinds of entrance fees, fare, ticket, donation or charges are made or are required of the invited guests to enter the location.

This rule is intended to implement Iowa Code section 123.95.

185—4.24(123) Alcoholic liquor and wine on beer permit premises. Alcoholic liquor and wine may not be kept, consumed, or dispensed for any purpose by any entity or individual on the premises of a Class “B” beer permit holder.

This rule is intended to implement Iowa Code section 123.141.

185—4.25(123) Age requirements. Persons 21 years of age or older may hold a liquor license, wine permit, or beer permit; however, persons who are between the ages of 18 and 21 and hold a liquor license, wine permit, or beer permit before September 1, 1986, are not affected by or subject to this rule, and may hold such license or permit even though the licensee or permittee has not attained the age of 21. Persons 18 years of age and older may be bartenders, waiters, waitresses, and may handle alcoholic beverages, wine, and beer during the course of the person’s employment for a licensee or permittee in establishments in which alcoholic beverages, wine, and beer are consumed. Persons 16 years of age and older may sell

beer and wine in off-premises beer and wine establishments. Persons must be 18 years of age or older to work in a state liquor store.

This rule is intended to implement Iowa Code sections 123.30, 123.47A and 123.49.

185—4.26(123) Timely filed status.

4.26(1) In addition to the requirements which may be imposed by a local authority upon the holder of an alcoholic beverages license or permit to obtain timely filed status of a renewal application, the division may grant timely filed status if the applicant complies with the following conditions:

a. The applicant files a completed application with the local authority or the division as required by applicable law.

b. The applicant files a current dram shop liability certificate with the local authority or the division if proof of dram shop liability is required as a condition precedent to the issuance of the license or permit.

c. The applicant pays the appropriate license or permit fee in full to the local authority or the division as required by applicable law.

d. The applicant files a bond with the local authority or the division if a bond is required as a condition precedent to the issuance of the license or permit under applicable law.

4.26(2) Timely filed status allows the holder of the license or permit to continue to operate under a license or permit after its expiration and until the local authority and the division have finally determined whether the license or permit should be issued. If the application for the license or permit is denied, timely filed status continues until the last day for seeking judicial review of the division's action.

4.26(3) An applicant for a new alcoholic beverages license or permit may not sell alcoholic liquor, wine or beer in the proposed establishment until a license or permit has been granted by the division.

This rule is intended to implement Iowa Code sections 123.32, 123.35 and 17A.18.

185—4.27(123) Effect of suspension. Subject to the right to convey a suspended establishment under Iowa Code section 123.39, no beer, wine, or liquor can be sold or consumed in an establishment during a suspension period. An establishment may be open during a suspension period to conduct lawful business other than the sale of liquor, wine, and beer as long as no liquor, wine, or beer is sold or consumed during the suspension period.

This rule is intended to implement Iowa Code section 123.39.

185—4.28(123) Use of establishment during hours alcoholic liquor, wine, and beer cannot be consumed. No one, including licensee, permittee, and employees can consume beer, wine, or alcoholic beverages in their licensed establishment during hours which beer, wine, and alcoholic beverages cannot be sold. An establishment covered by a liquor license, wine permit, or beer permit can be used as a restaurant or any other lawful purpose during hours which beer, wine, or alcoholic liquor cannot be sold as long as beer, wine, or alcoholic beverages are not consumed during these hours.

This rule is intended to implement Iowa Code section 123.49.

185—4.29 Rescinded, effective 7/1/85.

185—4.30(123) Persons producing fuel alcohol. Persons producing fuel alcohol for their own use or to be sold commercially do not have to obtain a license or permit from the division.

This rule is intended to implement Iowa Code sections 123.4 and 123.41.

185—4.31(123) Storage of beer. No retail liquor licensee or retail beer permittee shall store beer except on premises licensed for retail sale and then only to the extent that the beer is intended for sale to consumers from the individually licensed premises where stored. The adoption of this rule shall not preclude a retail liquor licensee or a retail beer permittee from picking up beer from Class "A" and "F" beer permittees and directly transporting the beer to the retail establishment where the beer is intended to be sold at retail.

This rule is intended to implement Iowa Code section 123.21.

185—4.32(123) Delivery of alcoholic liquor. Individuals who do not work for this division may operate a delivery service in which they will charge licensees a fee for picking up their alcoholic liquor orders at this division's liquor stores and delivering it to their establishments.

This rule is intended to implement Iowa Code sections 123.4 and 123.21(10).

185—4.33(123) Delivery of beer and wine. Licensees and permittees who hold a license or permit which allows them to sell bottled wine and bottled beer may deliver beer and wine to residences if the customers telephoned and requested that the beer and wine be delivered.

This rule is intended to implement Iowa Code subsection 123.21(10).

185—4.34(123) Determination of population. Decennial Censuses and Special Censuses done by the U.S. Census Bureau are recognized as being the official population of a town for the purpose of deciding the price of licenses and permits in that town, but estimates done by the U.S. Census Bureau cannot be viewed as being the official population when deciding the price of licenses and permits.

This rule is intended to implement Iowa Code subsection 123.21(11).

185—4.35(123) Minors in licensed establishments. Because Iowa law does not prohibit minors from being in licensed establishments, a minor can be in a licensed establishment if local authority does not have a local ordinance prohibiting minors from being in licensed establishments in its jurisdiction.

This rule is intended to implement Iowa Code subsection 123.21(5).

185—4.36(123) Sale of alcoholic liquor and wine stock when licensee or permittee sells business. When a licensee or permittee goes out of business, the licensee or permittee may sell the licensee's or permittee's stock of alcoholic liquor and wine to the person who is going to operate a licensed establishment in the same location.

This rule is intended to implement Iowa Code subsection 123.21(5).

185—4.37(123) Business as usual on election days. Licensees and permittees may sell alcoholic liquor, wine, or beer during regular hours on days local and national elections are held because present Iowa law does not restrict the sale of liquor, wine, and beer on election days.

This rule is intended to implement Iowa Code subsection 123.21(3).

185—4.38(123) Sunday sale of wine. A holder of a Class "B" wine permit or combination retail wine license, excluding any liquor control licensee or beer permittee which does not qualify for Sunday sales under Iowa Code sections 123.36(6) and 123.134(5), respectively, may sell wine for consumption off the premises between the hours of 10 a.m. and 12 midnight on Sundays. No fee shall be imposed for that privilege.

This rule is intended to implement Iowa Code subsection 123.49(2).

185—4.39(123) Intoxication notice. Rescinded IAB 8/18/93, effective 7/29/93.

185—4.40(123) Warehousing of beer and wine. A person holding a Class "A" wine permit or a Class "A" or "F" beer permit shall warehouse their wine or beer inventory within the state of Iowa. Persons issued a Class "A" wine permit or Class "A" or "F" beer permit prior to June 10, 1987, shall comply upon renewal or November 1, 1987, whichever date occurs first. A warehouse of a person holding a Class "A" wine permit or a Class "A" or "F" beer permit shall be considered a licensed premises.

This rule is intended to implement Iowa Code section 123.127.

185—4.41(123) Vending machines to dispense alcoholic beverages prohibited. A liquor control licensee or beer or wine permittee shall not install or permit the installation of vending machines on the licensed premises for the purpose of selling, dispensing or serving alcoholic beverages. A vending machine is defined as a slug, coin, currency or credit card operated mechanical device used for dispensing merchandise, including single cans of beer or other alcoholic beverages, and includes

a mechanical device operated by remote control and used for dispensing single cans of beer or other alcoholic beverages. A vending machine is not a unit installed in individual hotel or motel rooms used for the storage of alcoholic beverages and intended for the personal use of hotel or motel guests within the privacy of the guests' rooms.

This rule is intended to implement Iowa Code sections 123.47, 123.47A, 123.49(1), 123.49(2) "b," 123.49(2) "h," and 123.49(2) "k."

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² Two ARCs. See Alcoholic Beverages Division in IAB.

BANKING DIVISION[187]

Created within the Department of Commerce by 1986 Iowa Acts, chapter 1245. Prior to 4/22/87, for Chs 1 to 15 see Banking Department[140] Chs 1 to 4, 8, 9 and 21; for Ch 16 see Auditor of State[130], Ch 1.
Note: Iowa Code chapter 453 renumbered as chapter 12C in 1993 Iowa Code.

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CHAPTER 2
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187—2.1(17A,524) Organization of a state-chartered bank.

2.1(1) Application. Persons desiring to organize a state-chartered bank should first meet with the superintendent to discuss the proposal. An “Application to Organize a State Bank” and supplementary forms may be obtained for submission to the superintendent.

2.1(2) Investigation. The superintendent may conduct an investigation as deemed necessary.

2.1(3) Preliminary approval. The superintendent may grant preliminary approval of an application to organize a state-chartered bank. If preliminary approval is granted, the superintendent may, if it is determined that such action is necessary or desirable for the protection of the public interest, at any time withdraw that approval.

2.1(4) Decision. The superintendent shall approve or deny the application within 180 days after the application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant.

2.1(5) Corporate organization. The proposed state bank does not come into existence until articles of incorporation have been approved by the superintendent and filed and recorded by the secretary of state and a certificate of incorporation has been issued.

2.1(6) Commencement of business. If the superintendent is satisfied that the proposed state bank has met all requirements and conditions and is ready to commence business, the superintendent shall issue an Authorization To Do Business which provides that the state bank is authorized to commence business as of a specified date.

This rule is intended to implement Iowa Code section 524.303.

187—2.2(17A,524) Conversion of national bank into state bank.

2.2(1) Application. A national bank desiring to become a state-chartered bank should first meet with the superintendent to discuss the proposal. An application and supplementary forms may be obtained for submission to the superintendent.

2.2(2) Examination and investigation. The superintendent may conduct an examination or investigation of the national bank as deemed necessary.

2.2(3) Decision. The superintendent shall approve or deny the application within 90 days after the application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant.

2.2(4) Corporate documents. If approval is granted, articles of conversion with a plan of conversion attached shall be delivered to the secretary of state for filing and recording.

2.2(5) Commencement of business as state-chartered bank. The conversion shall be effective as of the date of filing of articles of conversion in the office of the secretary of state unless a later date is specified in the articles of conversion. The superintendent’s Authorization To Do Business as a state-chartered bank will be issued to be effective on the date of conversion.

2.2(6) Resulting state-chartered bank. The resulting state bank shall submit the oath of directors, list of shareholders, and certificate of elections and appointments to the superintendent on forms to be provided by the superintendent. The oath of directors is to be signed prior to the first meeting of the board of directors following the effective date of the conversion. The list of shareholders is to be completed as of the effective date of conversion.

This rule is intended to implement Iowa Code sections 524.1410 and 524.1413 to 524.1415.

187—2.3(17A,524) Merger or purchase and assumption.

2.3(1) Definition. For purposes of this rule, the term “merger” means a merger in which the resulting bank is a state-chartered bank.

2.3(2) Application. State banks or national and state banks desiring to merge or a state bank desiring to purchase the assets and assume the liabilities of another bank should first meet with the superintendent

to discuss the proposal. An application and supplementary forms may be obtained for submission to the superintendent.

2.3(3) *State-chartered bank as seller.* In the case of a purchase and assumption, if the bank being acquired is a state bank, appropriate forms and instructions for the voluntary liquidation of the bank may be obtained from the superintendent.

2.3(4) *Examination and investigation.* The superintendent may conduct an examination or investigation as deemed necessary.

2.3(5) *Decision.* The superintendent shall approve or deny the application within 90 days after the purchase and assumption application has been accepted for processing and within 180 days after the merger application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant. If the application is approved, the superintendent shall issue the appropriate authorizations.

2.3(6) *Cash out merger.* Before the superintendent approves any plan of merger that requires state bank shareholders to sell their shares of stock for cash, a determination shall be made by the superintendent that the cash price being paid for such shares is reasonable. The following factors may be considered by the superintendent in making the determination as to whether the cash out merger price for the bank stock is reasonable:

- a. The book value of the bank stock.
- b. Recent sales prices of the bank stock.
- c. Appraisals of the bank stock.
- d. Bank earnings and stock dividend payment history.
- e. Number of shares being purchased.
- f. Any other relevant factors as the superintendent may prescribe.

This rule is intended to implement Iowa Code sections 524.1401 to 524.1405.

187—2.4(17A,524) Establishment of a bank office.

2.4(1) *Application.* A state-chartered bank desiring to establish and operate a bank office shall submit to the superintendent an “Application to Establish a Bank Office,” which is available upon request.

2.4(2) *Investigation.* The superintendent may conduct an investigation as deemed necessary.

2.4(3) *Guidelines.* In determining whether to approve or deny a bank office application for other than a mobile office, a bank-owned courier service, or a convenience office, the superintendent will consider the following factors:

- a. Whether the convenience and needs of the public and existing customers of the applicant bank will be served by the proposed office.
- b. Whether the population density and other economic characteristics of the area primarily to be served by the proposed office afford reasonable promise of adequate support for the office.
- c. Whether the capital structure of the applicant bank is adequate in relation to the costs and anticipated increased business, if any, occasioned by the proposed office.
- d. The history of operation and management of the applicant bank.
- e. Such other factors as the superintendent may determine are relevant.

2.4(4) *Decision.* The superintendent shall approve or deny the application within 120 days after the application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant. If the application is approved, the superintendent shall issue a bank office certificate for the establishment and operation of the bank office to be effective on a specific date and at a designated location.

This rule is intended to implement Iowa Code sections 524.312, 524.1201, 524.1303, and 524.1403.

187—2.5(17A,524) Change of location of principal place of business or bank office.

2.5(1) *Application.* A state bank desiring to relocate its principal place of business or a bank office shall submit to the superintendent an “Application to Move Main Office or Bank Office,” which is available upon request.

2.5(2) Investigation. The superintendent may conduct an investigation as deemed necessary.

2.5(3) Decision. The superintendent shall approve or deny the application within 180 days after the application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant. If the application is approved, the superintendent shall issue the appropriate authorizations for the conduct of business at the new location.

This rule is intended to implement Iowa Code sections 524.312 and 524.1202.

187—2.6(17A,524) Change of control.

2.6(1) Application. An application by any person to purchase or otherwise acquire, directly or indirectly, outstanding shares of a state bank which would result in control or a change in control shall be submitted in the format requested by the superintendent and shall, at a minimum, contain the following information:

a. Copy of the agreement between the purchaser and seller for the sale of stock which results in the buyer acquiring a majority interest in the state bank.

b. Terms of any bank stock loan including the amount to be borrowed, rate of interest, number of years the loan is to run, collateral pledged to secure the indebtedness and any other pertinent information relating to such loan.

c. Financial statement of the purchaser and a résumé related to the purchaser's past experience and affiliations.

d. Pro forma statement of the purchaser's income and expenses during the term of the bank stock loan and a statement from the purchaser indicating which assets will be converted to cash or pledged as security to provide the initial equity.

e. Projections of statement of condition of the state bank to be purchased during the term of the bank stock loan.

f. Projections of income and expenses of the state bank to be purchased during the term of the bank stock loan.

g. Any plans which the purchaser may have which would represent major changes in the present staff or policies of the state bank involved.

h. When requested by the superintendent, an affidavit signed by the purchaser stating that the majority interest in the state bank is not being acquired for the benefit of another person or company.

2.6(2) Investigation. The superintendent may conduct an investigation as deemed necessary.

2.6(3) Decision. The superintendent shall approve or deny the application within 90 days after the application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant. If the application is approved, a certificate of approval, in letter form, will be delivered to the applicant. Upon receipt of such certificate, the applicant may proceed to conclude the purchase transaction, subject to such terms and conditions as the superintendent may impose.

This rule is intended to implement Iowa Code section 524.544.

187—2.7(17A,524) Renewal, amendment or restatement of articles of incorporation.

2.7(1) Application. Sample forms and instructions for making application to the superintendent to renew, amend or restate existing articles of incorporation of a state bank will be furnished upon request to the superintendent. State banks desiring to effect a reverse stock split or similar change in capital structure by such renewal, amendment, or restatement should contact the superintendent to discuss the proposal prior to its adoption.

2.7(2) Investigation. The superintendent may conduct an investigation as deemed necessary.

2.7(3) Reverse stock split. Before the superintendent approves any renewal, amendment, or restatement of existing articles of incorporation of a state bank that would effect a reverse stock split or similar change in the capital structure of the state bank and require any of its shareholders to surrender their shares of bank stock for cash, all of the following requirements shall have been satisfied:

a. The board of directors shall adopt a resolution granting all shareholders of the state bank the rights and remedies of a dissenting shareholder as provided for in Iowa Code chapter 490, division XIII;

b. The state bank shall have provided to all of its shareholders a full and adequate disclosure of all material aspects of the proposed transaction, which disclosure shall have accompanied the notice of the shareholder meeting held to consider the proposed renewal, amendment, or restatement of existing articles of incorporation; and

c. A determination shall have been made by the superintendent that the cash price being paid for the surrendered stock is reasonable. The following factors may be considered by the superintendent in making the determination as to whether the cash price for such stock is reasonable:

- (1) The book value of the bank stock;
- (2) Recent sales prices of the bank stock;
- (3) Appraisals of the bank stock;
- (4) Bank earnings and stock dividend payment history;
- (5) Total number of shares being surrendered; and
- (6) Any other relevant factors as the superintendent may prescribe.

2.7(4) Decision. The superintendent shall approve or deny the application within 90 days after the application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant. If the application is approved, the renewed, amended or restated articles of incorporation will be approved and forwarded to the secretary of state for filing and recording. Upon filing such articles, the secretary of state will return the original to the state bank and will also issue a certificate to the state bank indicating the date the filing was effective. Thereafter, the state bank will operate in accordance with its renewed, amended or restated articles of incorporation.

This rule is intended to implement Iowa Code sections 524.314, 524.1505, 524.1508, and 524.1509.

187—2.8(17A,524) Acquisition by regional bank holding company. Rescinded IAB 10/9/96, effective 11/13/96.

187—2.9(17A) Licensing of a debt management company.

2.9(1) Application. Persons desiring a license to operate a debt management company should contact the superintendent for the proper application and related forms.

2.9(2) Investigation. The superintendent may conduct such investigation as deemed necessary. Matters investigated include:

- a. The character, fitness, financial responsibility and experience of the applicant.
- b. A determination that applicant has not been convicted of a felony or a misdemeanor involving moral turpitude or had a record of defaulting in payment of money collected for others, including discharge of such debts through bankruptcy proceedings.
- c. A review of a current credit report to be submitted directly to the superintendent at the expense of the applicant.

2.9(3) Decision. The superintendent shall approve or deny the application within 60 days after the application has been accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant.

2.9(4) Exemptions. A debt management company may be exempted from licensure if it is a nonprofit religious, fraternal, or cooperative organization, including a credit union. The services provided by such a company must be gratuitous, meaning that the service is provided without charge or the imposition of a fee of any kind. The company may request donations, but that request must clearly indicate that the donations are voluntary and are not a requirement or condition for providing the debt management service. A donation shall be outside of the transaction, meaning that a donation shall not be deducted from a payment to a creditor or billed to a creditor.

This rule is intended to implement Iowa Code sections 533A.2(1)“f” and 533A.3.

187—2.10 Reserved.

187—2.11(17A) Securing permission from the superintendent to engage in the business of selling certain instruments for the payment of money. Rescinded ARC 0210C, IAB 7/11/12, effective 8/29/12.

187—2.12(17A,524) Supplemental application procedures.

2.12(1) Scope. Subrules 2.12(2) to 2.12(14) contain procedures by which the superintendent may reach informed decisions with respect to those applications which the superintendent shall deem a public hearing necessary. These procedures provide a method by which all persons interested in the subject matter of such applications or other cases in which a public hearing is deemed necessary may present their views. Nothing contained herein shall be construed to prevent interested persons from presenting their views in a more informal manner when deemed appropriate by the superintendent or to prevent the superintendent from conducting such other investigation as may be deemed appropriate.

2.12(2) Notice of filing of application. Except in the case of proposed transactions where notice by publication is governed by statute, the applicant shall, within 15 days after the superintendent has notified the applicant in writing that an application has been accepted for processing, publish one time in a newspaper of general circulation in the community in which the applicant proposes to engage in business a notice containing the name of the applicant or applicants, the subject matter of the application, and the date upon which the application was accepted for processing. Immediately thereafter, the applicant shall furnish the superintendent with proof of such publication. The superintendent may solicit, in whatever manner deemed appropriate, comments from banks which may be affected by or have an interest in the pending application.

2.12(3) Public file. The public file in each case shall consist of the application with supporting data and supplementary information with the exception of material deemed by the superintendent to be confidential. In addition, the public file shall contain all data and information submitted by interested persons in favor of or in opposition to such application, excluding any material deemed by the superintendent to be confidential. The superintendent or the superintendent's designee shall not deem information confidential for purposes of the two immediately preceding sentences unless the person submitting the information requests that such information be deemed confidential. All factual information contained in any internal investigation report made by a bank examiner shall also be made a part of the public file, unless deemed confidential by the superintendent.

a. The public file shall be available for inspection in the office of the superintendent upon request from a protesting person and to such other persons as the superintendent shall deem to have a direct interest therein during such periods of time as the superintendent shall prescribe.

b. No documentation in the public file may be removed from the superintendent's office by persons other than members of the superintendent's staff. Photocopies may be made available, on request, to protesting and other interested parties. The charge for such copies shall be made in accordance with a written schedule maintained by the superintendent.

2.12(4) Written comments and requests for an opportunity to be heard. Within ten days after the notice of publication described in subrule 2.12(2), any interested person may submit to the superintendent written comments concerning the application or a written request for an opportunity to be heard before the superintendent or the superintendent's designee. The request shall state the nature of the issues or facts to be presented and the reasons why written submissions would be insufficient to make an adequate presentation to the superintendent. In the absence of a request, the superintendent, when it is believed to be in the public interest, may order a hearing to be held.

2.12(5) Place of hearing. Hearings granted by the superintendent shall be heard in the office of the superintendent. The superintendent, in any matter, reserves the right to conduct hearings at any location deemed to be appropriate.

2.12(6) Date of hearing. An opportunity to be heard shall be given as soon as practicable after ordered.

2.12(7) Notice of hearing. The notice given by the superintendent concerning the hearing shall set forth the subject matter of the application, the legal authority for such hearing, and the date, time, and

place of the hearing. The notice shall be sent to the person or persons requesting the hearing, the applicant and to other interested persons who have sent written comments to the superintendent.

2.12(8) Attendance at hearing. Each person who wishes to be heard shall notify the superintendent within five days after the date of the notice described in subrule 2.12(7) of their intention to attend and shall submit the number and names of witnesses to be presented.

2.12(9) Presiding officer. The presiding officer at the hearing shall be the superintendent or such other person as may be designated by the superintendent.

2.12(10) Hearing rules. The applicant and each participant may make opening statements of a length within the discretion of the presiding officer. Such opening statements should concisely state what the participant intends to show. The applicant shall have the opportunity to present a statement first. Following the opening statements, the applicant shall present data and materials, oral or documentary. Following the applicant's presentation, the persons protesting the application shall present their data and materials, oral or documentary. The protesters may agree, with the approval of the presiding officer, to have one of their number make their presentation. Following the evidence of the applicant and the protester, the presiding officer may recognize other interested persons who may present their views with respect to the application under consideration. After all the above presentations have been concluded, the participants before the panel may make short and concise summary statements reviewing their position. The applicant shall present a concluding summary statement.

a. The obtaining and use of witnesses is the responsibility of the parties. All witnesses will be present on their own volition, but any person appearing as a witness may be subject to questioning by any participant. The refusal of a witness to answer questions may be considered by the superintendent in determining the weight to be accorded the testimony of that witness. Witnesses shall be sworn.

b. The presiding officer shall have the authority to exclude data or materials deemed to be improper or irrelevant. Formal rules of evidence shall not be applicable to these hearings. Documentary material must be of a size consistent with ease of handling, transportation and filing, and copies must be provided for each participant. While large exhibits may be used during the hearing, copies of such exhibits must be provided by the party in reduced size for submission as evidence. Two copies of all such documentary evidence shall be furnished to the superintendent, and one copy shall be furnished to each other person represented at the proceeding.

c. The superintendent or the superintendent's designee shall determine all procedural questions not governed by these rules. The superintendent or the superintendent's designee shall have the authority to limit the number of witnesses to be used by any party, and to impose such time limitations as shall be deemed reasonable.

d. A transcript of each proceeding shall be arranged for by the superintendent's office, with all expenses of such service, including the furnishing of one copy of the transcript to the superintendent, being borne by the person or persons requesting the opportunity to be heard, except for hearings ordered by the superintendent's office on its own volition, in which case, the applicant will bear the expense of furnishing transcripts of the record.

e. The public file described in subrule 2.12(3) shall automatically be deemed a part of the record of these proceedings as well as all evidence submitted and the transcript described in paragraph "d" of this subrule.

2.12(11) Closing of the public file. If requested by any participant, the public file shall remain open for five days following receipt of the transcript by the superintendent during which time the applicant and protesters may submit additional written statements. A copy of any statement so submitted during this period of time shall also be sent simultaneously to the other persons represented at the hearing.

2.12(12) Reserved.

2.12(13) Decision. The applicant and all persons so requesting in writing shall be notified of the final disposition of the application by the superintendent.

2.12(14) Computation of time. In computing any period of days provided for in this rule, the day of the event from which the period begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, a Sunday, or a legal holiday, in which event the

period runs until the end of the next day which is not a Saturday, a Sunday, or a legal holiday. As used in this subrule, “legal holiday” means a day on which the office of the superintendent remains closed.

This rule is intended to implement Iowa Code sections 17A.3, 524.305, 524.312, 524.1201, 524.1303, and 524.1403.

187—2.13(524) Integral facility determination. Rescinded IAB 3/2/05, effective 4/6/05.

187—2.14(524) Investment in a bank service corporation or other subsidiary.

2.14(1) Application. An application by a state bank to invest in a bank service corporation or other subsidiary for purposes of engaging in an authorized activity shall be in letter form and shall, at a minimum, contain the following information.

a. A detailed description of the proposed authorized activity of the bank service corporation or other subsidiary.

b. A detailed description of the location(s) where the bank service corporation or other subsidiary proposes to conduct its authorized activity.

c. Evidence that the bank service corporation or other subsidiary:

(1) Will be adequately capitalized in relation to the risks associated with the proposed authorized activity;

(2) Will have sufficient managerial resources to perform the proposed authorized activity;

(3) Will obtain all licenses and approvals from other regulatory agencies necessary to perform the proposed authorized activity;

(4) Will maintain a separate and adequate accounting system and other corporate records; and

(5) Will conduct its authorized activity pursuant to independent policies and procedures designed to inform customers and prospective customers of the bank service corporation or other subsidiary that it is a separate organization from the state bank.

d. A legal opinion that the proposed authorized activity of the bank service corporation or other subsidiary is permissible under state and federal laws and regulations, if requested by the superintendent.

e. The amount which the state bank proposes to initially invest in the bank service corporation or other subsidiary.

f. A copy of the resolution adopted by the state bank’s board of directors authorizing the investment in the bank service corporation or other subsidiary.

2.14(2) Investment limitation. Unless state or federal statutes impose specific limitations relating to investments in the shares of a corporation by a state bank, a state bank’s investment in a bank service corporation or other subsidiary shall not exceed 15 percent of its aggregate capital as defined in Iowa Code section 524.103, nor shall more than 5 percent of its total assets be invested in all bank service corporations or subsidiaries. At the superintendent’s discretion, a higher investment limitation may be established for an investment by a state bank in an operations subsidiary, as defined in section 524.103. For purposes of this rule, the terms “invest” or “investment” shall include any advance of funds to a bank service corporation or other subsidiary, whether by the purchase of stock, the making of a loan or otherwise.

2.14(3) Investigation. The superintendent may conduct an investigation as deemed necessary.

2.14(4) Decision. The superintendent shall approve or deny the application within 60 days after the application is accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant.

2.14(5) Revocation. The superintendent may revoke a previously granted approval to invest in a bank service corporation or another subsidiary and order divestiture of the shares, pursuant to the contested case provisions of Iowa Code chapter 17A, if any of the following occur.

a. The financial condition of the state bank has significantly deteriorated.

b. The superintendent determines the authorized activity is being conducted unlawfully or in an unsafe or unsound manner.

c. Other relevant factors occur which the superintendent may determine are grounds for a revocation of the authorized activity.

This rule is intended to implement Iowa Code chapter 524.

187—2.15(524) Securities activities.

2.15(1) Scope. Iowa law authorizes state-chartered banks to engage in any aspect of the securities business. The evolution of this authority by state banks has been confined primarily to recommending and selling interests in mutual funds, annuities, and other nondeposit investment products on bank premises. The sale of these nondeposit investment products on bank premises may be conducted directly by a state bank, through a subsidiary or an affiliate of a state bank, or through an arrangement with a third-party vendor. The sale of these retail products on the premises of a state bank, where traditionally only federally insured deposits are taken, has led to some confusion among retail customers about what is being purchased and whether or not it is insured. The purpose of this rule is to place greater emphasis on board of director involvement in any proposed securities activities on the premises of the state bank and, if retail product sales are part of that proposed activity, enhance customer protections through proper disclosures.

2.15(2) Board responsibilities. The board of directors of a state bank shall evaluate the risks associated with the securities activities proposed and the method by which the securities activities will be conducted on its premises. The board of directors shall be responsible for ensuring that any securities activities conducted on its premises will comply with all applicable state and federal laws and regulations as well as any policy statements issued which relate to securities activities. Specifically, if a state bank develops and implements a particular program where nondeposit investment products are recommended and sold to retail customers, that program shall ensure that customers are clearly and fully informed of the nature of and risks associated with those types of products. If an affiliate, a subsidiary, or a third-party vendor is used to recommend and sell nondeposit investment products, all signs, advertisements and other promotional material should clearly identify the affiliate, subsidiary, or third-party vendor as the seller and should not suggest by use of a trade name that the state bank is the seller. The board of directors shall be responsible for complying with the joint federal Interagency Statement on Retail Sales of Nondeposit Investment Products or any substitution therefor or revision thereof.

2.15(3) Application. An application by a state bank to engage in any securities activities shall be in letter form and shall, at a minimum, contain the following information.

a. A commitment that the proposed securities activities will be conducted either directly by the state bank, through a subsidiary or an affiliate of the state bank, or through an arrangement with a third-party vendor. In specific cases, it may be necessary for the applicant to provide a legal opinion stating that the proposed activities are authorized.

b. A commitment that the state bank's board of directors has evaluated the risks associated with the proposed securities activities and has adopted a written statement that addresses these risks and the procedures to be used to ensure compliance with all applicable laws, regulations and policy statements. The scope and level of detail of the written statement should reflect the state bank's level of involvement in the securities activities. If securities activities are to be conducted on bank premises by an affiliate, a subsidiary, or a third-party vendor, the written statement should also address the scope of those activities, as well as the procedures for monitoring compliance by the affiliate, subsidiary, or third-party vendor with all applicable laws, regulations and policy statements.

c. A commitment that, if securities activities are to be conducted through an affiliate, a subsidiary, or a third-party vendor, the board of directors has performed an appropriate review of the affiliate, subsidiary, or third-party vendor. A copy of the written agreement between the parties shall accompany the application.

d. A commitment that the location(s) on bank premises where the proposed securities activities will be conducted will be physically distinct and separate from the area where deposits are taken. Proper signs or other means must be used to distinguish the area where the sale of retail nondeposit investments products will be conducted from the area where insured deposits are normally taken. If

securities activities are to be conducted on bank premises by an affiliate, a subsidiary, or a third-party vendor, all signs or other means used to identify this area shall provide to the retail customer a clear and accurate representation of the entity conducting the securities activities.

e. A commitment that clear and concise oral and written disclosures will be provided to retail customers. A copy of the proposed written disclosures shall accompany the application.

f. A commitment that the state bank, its subsidiary or affiliate, or a third-party vendor will complete background checks on all personnel authorized to recommend and sell nondeposit investment products and that all such personnel will be properly trained and appropriately licensed prior to commencing any securities activities and thereafter while conducting securities activities on the premises of the state bank.

Notwithstanding the application requirements set forth herein, if the securities activity being conducted is limited to discount brokerage or referral services, then the state bank only needs to notify the superintendent that it intends to engage in the limited securities activity.

2.15(4) Investigation. The superintendent may conduct an investigation as deemed necessary.

2.15(5) Decision. The superintendent shall approve or deny the application within 60 days after the application is accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant.

2.15(6) Revocation. The superintendent may revoke a previously granted approval to conduct securities activities on the premises of the state bank, pursuant to the contested case provisions of Iowa Code chapter 17A, if any of the following occur.

a. The financial condition of the state bank has significantly deteriorated.

b. The superintendent determines the securities activities are being conducted unlawfully or in a unsafe or unsound manner.

c. Other relevant factors occur which the superintendent may determine are grounds for a revocation of the securities activities.

This rule is intended to implement Iowa Code section 524.825.

187—2.16(524) Contracts.

2.16(1) Scope. Futures contracts shall be defined as standardized contracts traded on and guaranteed by organized exchanges to purchase or sell a specified security or a bank certificate of deposit on a future date at a specified price. Forward contracts shall be defined as over-the-counter contracts for forward placement or delayed delivery of securities in which one party agrees to purchase and another to sell a specified security at a specified price for future delivery. Contracts specifying settlement in excess of 30 days following the trade date shall be deemed to be forward contracts. Standby contracts shall be defined as optional forward contracts. For an example, the buyer of a standby contract (put option) pays a fee for the right or option to sell securities to the other party at a stated price at a future time. The seller of a standby contract receives the fee and must stand ready to buy the securities at the other party's option.

Futures contracts, forward contracts and standby contracts may be used by the state banks to reduce their existing interest rate risk exposure resulting from their overall investment activities and as a general hedge against interest rate exposure associated with undesired mismatches in interest-sensitive assets and liabilities. At no time shall futures, forward and standby contracts be used to speculate on future interest rate movements.

State banks may, without the prior approval of the superintendent, purchase shares in permissible investment companies, up to a maximum of 15 percent of aggregate capital, which use futures contracts, forward contracts and standby contracts, as well as repurchase agreements and securities lending arrangements as a part of their portfolio management strategies. However, it remains the responsibility of the board of directors making these purchases to ensure that a particular investment company is a proper holding for the bank's investment portfolio.

2.16(2) Application. An application by a state bank to engage in futures contracts, forward contracts and standby contracts shall be in letter form and shall, at a minimum, contain the following information.

a. A description of the type(s) of contracts the state bank proposes to purchase and sell.

b. A copy of the board of directors' resolution authorizing the specific type(s) of contracts proposed to be purchased and sold.

c. A copy of the policy adopted by the state bank's board of directors which shall include specific policy objectives that outline permissible contract strategies and their relationship to overall investment activities and asset-liability management; the names, responsibilities, and authority limits of the personnel authorized to engage in futures, forward and standby contracts; limitations applicable to futures, forward and standby contract positions; the personnel to be used to review at least monthly the bank's contract positions to ascertain compliance with such limits; the exchanges and firms through which authorized personnel may conduct futures, forward and standby contracts; and the dollar limit on transactions with each firm.

d. A representation that the state bank has sufficient managerial resources to engage in futures, forward and standby contracts.

e. A copy of the board of directors' resolution stating that the board members have read and understood the "Federal Deposit Insurance Corporation Statement of Policy Concerning Interest Rate Futures Contracts, Forward Contracts, and Standby Contracts" and will comply with the policy statement.

2.16(3) Investigation. The superintendent may conduct an investigation as deemed necessary.

2.16(4) Decision. The superintendent shall approve or deny the application within 60 days after the application is accepted for processing. The decision by the superintendent shall be conveyed in writing to the applicant.

2.16(5) Revocation. The superintendent may revoke the approval of the state bank to engage in futures, forward and standby contracts, pursuant to the contested case provisions of Iowa Code chapter 17A, if any of the following occur.

a. The financial condition of the state bank has significantly deteriorated.

b. The superintendent determines the futures, forward or standby contract activities are being conducted unlawfully or in an unsafe or unsound manner.

c. Other relevant factors occur which the superintendent may determine are grounds for a revocation of the activities.

This rule is intended to implement Iowa Code section 524.901.

187—2.17(17A,524) Mobile offices, courier services, and convenience offices.

2.17(1) Definitions.

"*Bank-owned courier service*" means a service that has the sole purpose of serving specific customers with pick-up or delivery services for banking activities such as deposits, withdrawals, and loan transactions.

"*Convenience office*" means a bank office at a fixed site that is open only at certain times or dates, such as at a nursing home, college orientation, or fair. The sole purpose of a convenience office is to serve the convenience of the bank's customers at specified special events or who may have limited mobility.

"*Mobile office*" means a bank office that does not have a permanent site and functions out of a mobile banking unit that stops at predetermined locations to conduct banking activities.

2.17(2) Policy. The board of directors of a state bank that operates a mobile office, bank-owned courier service, or convenience office shall adopt a policy governing operation of the mobile office, bank-owned courier service or convenience office. The policy shall be appropriate for the nature and scope of the state bank's use of the mobile office, bank-owned courier service, or convenience office and shall, at a minimum, include the following:

a. The policy shall address the steps the bank will take to protect the security of the office, its customers, employees, its customers' financial information and deposits. The security plan may include implementation of customer and employee security systems such as security cameras, external lighting, and internal or attached protection zones.

b. The policy shall require the bank to maintain deposit insurance coverage for the mobile office, bank-owned courier service, or convenience office.

c. The policy shall require the bank to main adequate insurance coverage covering the bank in case of robbery, accident, other loss of items, delay in the delivery of items to other destinations, and other liabilities associated with operating the office.

d. The policy shall address types of activities the bank will conduct from the mobile office, bank-owned courier service, or convenience office.

e. The policy shall require a bank office manager or officer of the bank to be physically present at the mobile office, bank-owned courier service, or convenience office during a majority of its business hours as required by Iowa Code section 524.1201.

f. The policy shall require the bank to maintain a daily log of operations including descriptions of the time and locations of each stop made by the mobile office or bank-owned courier service, the locations and the hours a convenience office was operated and the names of the bank personnel working at the mobile office, bank-owned courier service, or convenience office during those times.

g. The policy shall address what, if any, signage the bank will place on the mobile office, bank-owned courier service, or convenience office.

h. For mobile offices and bank-owned courier services, the policy shall address how the bank will determine the locations at which it will provide services and the times it will be at those locations. The policy shall address how the bank will ensure that the mobile office, bank-owned courier service, or convenience office is located in a safe location and that it has the necessary permission of the owner of the property where the mobile office, bank-owned courier service, or convenience office is located to operate at that location.

2.17(3) Publication requirements. A bank that submits an application to operate a mobile office or bank-owned courier service shall describe the general geographic area to be served by the mobile office or courier service in the notice of application it publishes pursuant to 187 IAC 2.12(2). Publication in several newspapers may be required to establish mobile offices or bank-owned courier services that will serve several communities or geographic areas. The publication need not identify specific sites to be served by the mobile office or courier service, but should state the general geographic area to be served, such as the city, county, or other identifiable geographic area. Changes in the general geographic area to be served require additional publication of notice in the new geographic areas and are subject to approval by the superintendent.

2.17(4) Necessary federal approval. If the bank must receive approval from any federal agency, such as the Federal Deposit Insurance Corporation (FDIC), prior to operating a mobile office, bank-owned courier service, or convenience office, such federal approval will be a condition of approval by the superintendent of banking of the application to operate a mobile office, bank-owned courier service, or convenience office.

2.17(5) Interstate banking. A mobile office or bank-owned courier service shall not operate in another state unless it has obtained any required permissions from the other state and the appropriate federal regulator.

This rule is intended to implement Iowa Code section 524.1201.

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Rescinded **ARC 0210C**, IAB 7/11/12, effective 8/29/12

HUMAN SERVICES DEPARTMENT[441]

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

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

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 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. Medical assistance shall also be available to the individual’s dependent relative as defined in 441—subrule 51.4(4).

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.
 - (4) They receive earned income from employment or self-employment or are eligible under paragraph "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 (1) above.
 - (6) They have paid any premium assessed under paragraph "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. 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	\$46
180% of Federal Poverty Level	\$56
200% of Federal Poverty Level	\$66
225% of Federal Poverty Level	\$78
250% of Federal Poverty Level	\$88
300% of Federal Poverty Level	\$108
350% of Federal Poverty Level	\$130
400% of Federal Poverty Level	\$152
450% of Federal Poverty Level	\$174
550% of Federal Poverty Level	\$215
650% of Federal Poverty Level	\$257
750% of Federal Poverty Level	\$300
850% of Federal Poverty Level	\$344
1000% of Federal Poverty Level	\$409
1150% of Federal Poverty Level	\$481
1300% of Federal Poverty Level	\$574
1480% of Federal Poverty Level	\$667

(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 uninsured or have health insurance that does not include family planning services, are not otherwise enrolled in Medicaid (other than IowaCare), and are not enrolled in the Children's Health Insurance Program (HAWK-I):

(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 300 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 300 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 441—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 441—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 441—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 441—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.

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]

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. As a condition of eligibility, a person for whom Medicaid is being requested or received must furnish a social security account number or must furnish proof of application for the number if the social security number has not been issued or is not known and provide the number upon receipt. This requirement does not apply if the person refuses to obtain a social security number because of well-established religious objections. The term “well-established religious objections” means that the person is a member of a recognized religious sect or a division of a recognized religious sect and adheres to the tenets or teachings of the sect or division, and for that reason is conscientiously opposed to applying for or using a national identification number.

75.7(1) Assistance shall not be denied, delayed, or discontinued pending the issuance or verification of the numbers when the applicants or recipients are cooperating in providing information necessary for issuance of their social security numbers.

75.7(2) The mother of a newborn child shall have until the second month following the mother’s discharge from the hospital to apply for a social security account number for the child.

75.7(3) Social security account numbers may be requested for people in the eligible group for whom Medicaid is not being requested or received, but provision of the number shall not be a condition of eligibility for the people in the eligible group for whom Medicaid is being requested or received.

This rule is intended to implement Iowa Code section 249A.3.

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.

“Incapable of expressing intent” shall mean that the person meets one or more of the following conditions:

1. Has an IQ of 49 or less or has a mental age of seven or less.
2. Is judged legally incompetent.
3. Is found incapable of indicating intent based on medical documentation obtained from a physician, psychologist or other person licensed by the state in the field of mental retardation.

“Institution” shall mean an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Foster care facilities are included.

75.10(2) Determining residency. Residency is determined according to the following criteria:

a. Persons aged 21 and over.

(1) For any person not residing in an institution the state of residence is the state where the person is:

1. Living with the intention to remain there permanently or for an indefinite period (or, if incapable of expressing intent, where the person is living), or
2. Living and which the person entered with a job commitment or seeking employment (whether or not currently employed).

(2) For any institutionalized person who became incapable of indicating intent before age 21, the person’s state of residence is:

1. That of the parent applying for Medicaid on the person’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 the parent’s.
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 the parent’s.

3. The current state of residence of the parent or legal guardian who files the application if the person is institutionalized in the state. If a legal guardian has been appointed and parental rights are terminated, the state of residence of the guardian is used instead of the parent’s.

4. The state of residence of the person who has been abandoned by the person’s parents and does not have a legal guardian is the state in which the person is institutionalized.

(3) For any institutionalized person who became incapable of expressing intent at or after age 21, the state of residence is the state in which the person is physically present, except where another state makes a placement.

(4) For any other institutionalized person the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

b. Persons under age 21.

(1) For any person who is emancipated from the person's parents or who is married and capable of expressing intent, the state of residence is the state where the person is living with the intention to remain there permanently or for an indefinite period.

(2) For any person not residing in an institution or foster home whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the person is living.

(3) For any other person not in an institution or foster home and not subject to subparagraph (1) or (2) above, the state of residence is determined in accordance with rule 441—75.53(249A).

(4) For any person in an institution or foster home 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 the parent's.

2. The current state of residence of the parent or legal guardian who files the application if the person is in institutionalized or in foster care 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 the parent's.

3. The state of residence of the person who has been abandoned by the person's parents and does not have a legal guardian is the state in which the person is institutionalized or in foster care.

c. Persons placed by a state in an out-of-state foster home or institution. A state arranging or actually making the placement of a person in an institution or foster home in another state is considered the person's state of residence. However, a Title IV-E eligible child placed out of state by the department is eligible for Medicaid from the other state. Therefore, the Title IV-E eligible child shall only receive Iowa Medicaid until the receiving state provides coverage. A Title IV-E eligible child placed in Iowa by another state shall be considered eligible for Iowa Medicaid.

d. Medicaid-eligible persons receiving Medicaid from another state and gaining Iowa residency. These persons shall be granted Medicaid beginning with the month of residency in Iowa if the person is otherwise eligible and surrenders the other state's medical card. Good cause for not surrendering the other state's medical card shall exist when:

(1) The other state does not issue medical cards.

(2) The other state's medical card is a magnetic stripe or a computer chip card that contains more than Medicaid-related information.

(3) The other state's medical card: was left with Medicaid-eligible members of the person's household in the other state who did not move to Iowa with the person; was lost, mutilated, or destroyed; was not kept by the person upon the person's move to Iowa; or was previously surrendered to the other state.

In addition to surrendering the other state's medical card or establishing good cause, the cancellation of Medicaid in the other state shall be verified.

This rule is intended to implement Iowa Code section 249A.3.

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) *Condition of eligibility for group plans.* The Medicaid member or a person acting on the member's behalf shall cooperate in providing information necessary for the department to establish availability and the cost-effectiveness of a group health plan. When the department has determined that a group health plan is cost-effective, enrollment in the plan is a condition of Medicaid eligibility unless it can be established that insurance is being maintained on the Medicaid members through another source (e.g., an absent parent is maintaining insurance on the Medicaid-eligible children).

a. When a parent fails to provide information necessary to determine availability and cost-effectiveness of a group health plan, fails to enroll in a group health plan that has been determined cost-effective, or disenrolls from a group health plan that has been determined cost-effective, Medicaid benefits of the parent shall be terminated unless good cause for failure to cooperate is established.

b. Good cause for failure to cooperate shall be established when the parent or family demonstrates one or more of the following conditions exist:

- (1) There was a serious illness or death of the parent or a member of the parent's family.
- (2) There was a family emergency or household disaster, such as a fire, flood, or tornado.
- (3) The parent offers a good cause beyond the parent's control.
- (4) There was a failure to receive the department's request for information or notification for a reason not attributable to the parent. Lack of a forwarding address is attributable to the parent.

c. Medicaid benefits of a child shall not be terminated due to the failure of the parent to cooperate. Additionally, the Medicaid benefits of a spouse who cannot enroll in the plan independently of the other spouse shall not be terminated due to the other spouse's failure to cooperate.

d. The presence of good cause does not relieve the parent of the requirement to cooperate. When necessary, the parent may be given additional time to cooperate when good cause is determined to exist.

75.21(2) *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(3).

75.21(3) *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(4) 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(5) 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) or the IowaCare program in accordance with the provisions of 441—Chapter 92. 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 insurance is a Medicare supplemental policy and the Health Insurance Premium Payment Application, Form 470-2875, was received on or after March 1, 1996.

k. 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.

l. 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).

m. The health plan pays secondary to another plan.

n. The only Medicaid members covered by the health plan are currently in foster care.

o. 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(6) 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(7) 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(8) 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(9) 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(10) 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(11) Reviews of cost-effectiveness and eligibility. Reviews of cost-effectiveness and eligibility shall be completed annually and may be conducted more frequently at the discretion of the department.

a. For a group health plan, the review of cost-effectiveness and eligibility may be completed at the time of the health plan contract renewal date. The employer shall complete Health Insurance Premium Payment (HIPP) Program Review, Form 470-3016, for the review.

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

c. Failure of the household to cooperate in the review process shall result in cancellation of premium payment and may result in Medicaid ineligibility as provided in subrule 75.21(1).

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(16) "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(12) *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(8)) 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(13) *Notices.*

a. An adequate notice shall be provided to the household under the following circumstances:

(1) To inform the household of the initial decision on cost-effectiveness and premium payment.

(2) To inform the household that premium payments are being discontinued because Medicaid eligibility has been lost by all persons covered under the health plan.

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

b. The department shall provide a timely and adequate notice as defined in 441—subrule 7.7(1) to inform the household of a decision to discontinue payment of the health insurance premium because:

(1) The department has determined the health plan is no longer cost-effective, or

(2) The member has failed to cooperate in providing information necessary to establish continued eligibility for the program.

75.21(14) *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(15) *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(16) *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(3) and 75.21(4).

75.21(17) *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]

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(9).

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, 2012, through June 30, 2013, this average statewide cost shall be \$5,131.82 per month or \$168.81 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]

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, 2012, to June 30, 2013, shall be as follows:

- (1) The average statewide charge to a private-pay resident of a nursing facility is \$4,762 per month.
- (2) The maximum statewide Medicaid rate for a resident of an intermediate care facility for persons with an intellectual disability is \$23,801 per month.

(3) The average statewide charge to a resident of a mental health institute is \$18,546 per month.

(4) The average statewide charge to a private-pay resident of a psychiatric medical institution for children is \$5,472 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]

441—75.25(249A) Definitions. Unless otherwise specified, the definitions in this rule shall apply to 441—Chapters 75 through 85 and 88.

“Aged” shall mean a person 65 years of age or older.

“Applicant” shall mean a person who is requesting assistance, including recertification under the medically needy program, on the person's own behalf or on behalf of another person. This also includes parents living in the home with the children and the nonparental relative who is requesting assistance for the children.

“Blind” shall mean a person with central visual acuity of 20/200 or less in the better eye with use of corrective lens or visual field restriction to 20 degrees or less.

“Break in assistance” for medically needy shall mean the lapse of more than three months from the end of the medically needy certification period to the beginning of the next current certification period.

“Central office” shall mean the state administrative office of the department of human services.

“Certification period” for medically needy shall mean the period of time not to exceed two consecutive months in which a person is conditionally eligible.

“Client” shall mean all of the following:

1. A Medicaid applicant;
2. A Medicaid member;
3. A person who is conditionally eligible for Medicaid; and
4. A person whose income or assets are considered in determining eligibility for an applicant or member.

“CMAP-related medically needy” shall mean those individuals under the age of 21 who would be eligible for the child medical assistance program except for excess income or resources.

“Community spouse” shall mean a spouse of an institutionalized spouse for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“Conditionally eligible” shall mean that a person has completed the application process and has been assigned a medically needy certification period and spenddown amount but has not met the spenddown amount for the certification period or has been assigned a monthly premium but has not yet paid the premium for that month.

“Coverage group” shall mean a group of persons who meet certain common eligibility requirements.

“Department” shall mean the Iowa department of human services.

“Disabled” shall mean a person who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 months from the date of application.

“FMAP-related medically needy” shall mean those persons who would be eligible for the family medical assistance program except for excess income or resources.

“Health insurance” shall mean protection which provides payment of benefits for covered sickness or injury.

“Incurred medical expenses” for medically needy shall mean (1) medical bills paid by a client, responsible relative, or state or political subdivision program other than Medicaid during the retroactive certification period or certification period, or (2) unpaid medical expenses for which the client or responsible relative remains obligated.

“Institutionalized person” shall mean a person who is an inpatient in a nursing facility or a Medicare-certified skilled nursing facility, who is an inpatient in a medical institution and for whom payment is made based on a level of care provided in a nursing facility, or who is a person described in 75.1(18) for the purposes of rule 441—75.5(249A).

“Institutionalized spouse” shall mean a married person living in a medical institution, or nursing facility, or home- and community-based waiver setting who is likely to remain living in these circumstances for at least 30 consecutive days, and whose spouse is not in a medical institution or nursing facility for the purposes of rules 441—75.5(249A), 441—75.16(249A), and 441—76.10(249A).

“Local office” shall mean the county office of the department of human services or the mental health institute or hospital school.

“Medically needy income level (MNIL)” shall mean 133 1/3 percent of the schedule of basic needs based on family size. (See subrule 75.58(2).)

“Member” shall mean a person who has been determined eligible for medical assistance under rule 441—75.1(249A). For the medically needy program, “member” shall mean a medically needy person who has income at or less than the medically needy income level (MNIL) or who has reduced countable income to the MNIL during the certification period through spenddown. “Member” may be used interchangeably with “recipient.” This definition does not apply to the phrase “household member.”

“Necessary medical and remedial services” for medically needy shall mean medical services recognized by law which are currently covered under the Iowa Medicaid program.

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

“Nursing facility services” shall mean the level of care provided in a medical institution licensed for nursing services or skilled nursing services for the purposes of rule 441—75.23(249A).

“Obligated medical expense” for medically needy shall mean a medical expense for which the client or responsible relative continues to be legally liable.

“Ongoing eligibility” for medically needy shall mean that eligibility continues for an SSI-related, CMAP-related, or FMAP-related medically needy person with a zero spenddown.

“Pay and chase” shall mean that the state pays the total amount allowed under the agency’s payment schedule and then seeks reimbursement from the liable third party. The pay and chase provision applies to Medicaid claims for prenatal care, for preventive pediatric services, and for all services provided to a person for whom there is court-ordered medical support.

“Payee” refers to an SSI payee as defined in Iowa Code subsections 633.33(7) and 633.3(20).

“Recertification” in the medically needy coverage group shall mean establishing a new certification period when the previous period has expired and there has not been a break in assistance.

“Recipient” shall mean a person who is receiving assistance including receiving assistance for another person.

“Responsible relative” for medically needy shall mean a spouse, parent, or stepparent living in the household of the client.

“Retroactive certification period” for medically needy shall mean one, two, or three calendar months prior to the date of application. The retroactive certification period begins with the first month Medicaid-covered services were received and continues to the end of the month immediately prior to the month of application.

“Retroactive period” shall mean the three calendar months immediately preceding the month in which an application is filed.

“Spendedown” shall mean the process by which a medically needy person obligates excess income for allowable medical expenses to reduce income to the appropriate MNIL.

“SSI-related” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except that income shall be considered prospectively.

“SSI-related medically needy” shall mean those persons whose eligibility is derived from regulations governing the supplemental security income (SSI) program except for income or resources.

“Supply” shall mean the requested information is received by the department by the specified due date.

“Transfer of assets” shall mean transfer of resources or income for less than fair market value for the purposes of rule 441—75.23(249A). For example, a transfer of resources or income could include establishing a trust, contributing to a charity, removing a name from a resource or income, or reducing ownership interest in a resource or income.

“Unborn child” shall include an unborn child during the entire term of pregnancy.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.
[ARC 7935B, IAB 7/1/09, effective 9/1/09]

441—75.26(249A) References to the family investment program. Rescinded IAB 10/8/97, effective 12/1/97.

441—75.27(249A) AIDS/HIV settlement payments. The following payments are exempt as income and resources when determining eligibility for or the amount of Medicaid benefits under any coverage group if the payments are kept in a separate, identifiable account:

75.27(1) Class settlement payments. Payments made from any fund established pursuant to a class settlement in the case of *Susan Walker v. Bayer Corporation, et al.*, 96-C-5024 (N.D. Ill.) are exempt.

75.27(2) Other settlement payments. Payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement referred to in subrule 75.27(1) and that is signed by all affected parties in the cases on or before the later of December 31, 1997, or the date that is 270 days after the date on which the release is first sent to the person (or the legal representative of the person) to whom payment is to be made are exempt.

This rule is intended to implement Iowa Code sections 249A.3 and 249A.4.

441—75.28 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) An individual is out of the home to secure education or training as defined for children in paragraph 75.54(1) "b" as long as the child remains a dependent and as defined for adults in 441—subrule 93.114(1), first sentence.

(3) An individual is out of the home for reasons other than reasons in subparagraphs (1) and (2) 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.

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.

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

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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. Pharmacies are eligible to participate providing they are licensed in the state of Iowa or duly licensed in other states.

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 enrolled in the Iowa Plan for Behavioral Health pursuant to 441—Chapter 88, Division IV. Providers must complete child abuse, dependent adult abuse, and criminal background screenings pursuant to Iowa Code section 135C.33(5)“a”(1) before employment of a staff member who will provide direct care.

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]

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 standards of the National Register of Health Service Providers in Psychology, 1981 edition, published by the council for the National Register of Health Service Providers in Psychology, 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 standards of the National Register of Health Service Providers in Psychology.

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

“*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 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. The department of human services, a county or consortium of counties, or a provider under subcontract to the department or to a county or consortium of counties is eligible to participate in the home- and community-based habilitation services program as a provider of case management services provided that the agency meets the standards in 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.

j. A residential care facility of more than 16 beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

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.

g. A residential care facility of 16 or fewer beds that is licensed by the Iowa department of inspections and appeals, was enrolled as a provider of rehabilitation services for adults with chronic mental illness before December 31, 2006, and has applied for accreditation through one of the accrediting bodies listed in this subrule.

(1) The facility must have policies in place by June 30, 2007, consistent with the accreditation being sought.

(2) A facility that has not received accreditation within 12 months after application for accreditation is no longer a qualified provider.

77.25(8) Prevocational habilitation. The following providers may provide prevocational services:

a. 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.

b. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.

c. An agency that is accredited by the International Center for Clubhouse Development.

d. 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).

77.25(9) Supported employment habilitation. The following agencies may provide supported employment services:

- a. 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).
- b. 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.
- c. An agency that is accredited by the Council on Accreditation of Services for Families and Children.
- d. An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- e. An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities.
- f. An agency that is accredited by the International Center for Clubhouse Development.

77.25(10) Provider enrollment. A prospective provider that meets the criteria in this rule shall be enrolled as an approved provider of a specific component of home- and community-based habilitation services. Enrollment carries no assurance that the approved provider will receive funding. Payment for services will be made to a provider only upon department approval of the provider and of the service the provider is authorized to provide.

- a. The Iowa Medicaid enterprise shall review compliance with standards for initial enrollment. Review of a provider may occur at any time.
- b. The department may request any information from the prospective service provider that is pertinent to arriving at an enrollment decision. This information may include:
 - (1) Current accreditations.
 - (2) Evaluations.
 - (3) Inspection reports.
 - (4) Reviews by regulatory and licensing agencies and associations.

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]

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 rule 282—15.11(272);

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.

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 meet the standards in 441—Chapter 24 when they are the department of human services, a county or consortium of counties, or an agency or provider under subcontract to the department or a county or consortium of counties providing case

management services to persons with mental retardation, developmental disabilities or chronic mental illness.

77.29(2) Standards in 441—Chapter 186. Rescinded IAB 10/12/05, effective 10/1/05.

441—77.30(249A) HCBS ill and handicapped waiver service providers. HCBS ill and handicapped 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 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 ill and handicapped 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) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.
 - (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.

77.30(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) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.
 - (2) Rescinded IAB 9/1/04, effective 11/1/04.
 - (3) Rescinded IAB 9/1/04, effective 11/1/04.
 - (4) Home health agencies certified to participate in the Medicare program.
 - (5) 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 ill and handicapped 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 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]

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 ill and handicapped 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.

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 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]

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) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(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.

77.34(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 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]

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 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.

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 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 consumer 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 consumer, 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 consumers 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, 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) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.

(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.

77.37(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 of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities 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) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

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 ill and handicapped 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) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) 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 Form 470-3273, Mental Retardation Functional Assessment Tool.

(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 Form 470-3273, Mental Retardation Functional Assessment Tool.

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 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 consumer 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 consumer 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 consumers deemed to be at risk.

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.

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 services providers. Providers of prevocational services must be accredited by one of the following:

- a. The Commission on Accreditation of Rehabilitation Facilities as a work adjustment service provider or an organizational employment service provider.
- b. The Council on Quality and Leadership.

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]

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. Providers and each of their staff members involved in direct consumer service must have training regarding or experience with consumers who have a brain injury, with the exception of 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.

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 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 consumer 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 consumer, 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 consumers 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, 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) Child care facilities, which are defined as child care centers, preschools, or child development homes registered pursuant to 441—Chapter 110.
- (11) 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 of Services for Families and Children for similar services.

(3) An agency that is accredited by the Joint Commission on Accreditation of Healthcare Organizations for similar services.

(4) An agency that is accredited by the Council on Quality and Leadership in Supports for People with Disabilities 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) Member vacation, sick leave and holiday compensation.

(2) Procedures for payment schedules and pay scale.

(3) Procedures for provision of workers' compensation insurance.

(4) Procedures for the determination and review of commensurate wages.

c. The department will contract only with public or private agencies to provide supported employment services. The department does not recognize individuals as service providers under the supported employment program.

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 ill and handicapped 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.

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.* Providers of prevocational services must meet the Commission on Accreditation of Rehabilitation Facilities standards for work adjustment service providers.

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) Child care facilities, which are defined as child care centers licensed pursuant to 441—Chapter 109, preschools, or child development homes registered pursuant to 441—Chapter 110.

(2) Rescinded IAB 9/1/04, effective 11/1/04.

(3) Rescinded IAB 9/1/04, effective 11/1/04.

(4) Home health agencies certified to participate in the Medicare program.

(5) 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]

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 ill and handicapped 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.

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 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]

441—77.42(249A) Rehabilitation services to adults with chronic mental illness providers. Rescinded IAB 8/1/07, effective 9/5/07.

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 service 638 facilities. A health care facility owned and operated by American Indian or Alaskan native tribes or tribal organizations with funding authorized by Title I or Title III of the Indian Self-Determination and Education Assistance Act (P.L. 93-638) 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.

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 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) Child care centers licensed in good standing by the department according to 441—Chapter 109 and child development homes registered according to 441—Chapter 110.
 - (4) Camps certified in good standing by the American Camping Association.
 - (5) Home health agencies that are certified in good standing to participate in the Medicare program.
 - (6) 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.
 - (7) 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.
 - (8) Assisted living programs certified in good standing by the department of inspections and appeals.
 - (9) Residential care facilities for persons with mental retardation licensed in good standing by the department of inspections and appeals.

(10) 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]

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.

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.

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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, therapeutically certified 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. Payment will not be made for biological supplies and drugs provided free of charge to practitioners by the state department of public health. Rate of payment shall be established as in subrule 78.2(2), but no professional fee shall be paid.

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

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 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 Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have a wide variation in the relative frequency the procedures are performed. Preprocedure surgical review applies to surgeries performed in hospitals (outpatient and inpatient) and ambulatory surgical centers. Approval by the IFMC will be granted only if the procedures are determined to be necessary based on the condition of the patient and the published criteria established by the IFMC and the department. If not so approved by the IFMC, payment will not be made under the program to the physician or to the facility

in which the surgery is performed. The criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices.

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

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 bone marrow transplants for the treatment of aplastic anemia, severe combined immunodeficiency disease, Wiskott-Aldrich syndrome, or the following types of leukemia: acute myelocytic leukemia in relapse or remission, chronic myelogenous leukemia, and acute lymphocytic leukemia in remission.

(3) Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor; resistant non-Hodgkin’s lymphomas; lymphomas presenting poor prognostic features; recurrent or refractory neuroblastoma; or advanced Hodgkin’s disease when conventional therapy has failed and there is no matched donor.

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

Liver transplants require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) “f.”)

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

(5) Heart transplants. Artificial hearts and ventricular assist devices, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants, 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 and heart-lung transplants described above require preprocedure review by the Iowa Foundation for Medical Care. (Cross-reference 78.1(19) and 78.28(1) “f.”) Covered heart transplants are payable only when performed in a facility that meets the requirements of 78.3(10).

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

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

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

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

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

- Clinical problems with exogenous insulin therapy that are so severe as to be incapacitating.

- Consistent failure of insulin-based management to prevent acute complications.

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

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

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

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 Dental Terminology, Third Edition (CDT-3), for the purpose of preventing the worsening of early childhood caries in children aged 0 to 36 months of age, when rendered by physicians 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]

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, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner).

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).

78.2(5) *Nonprescription drugs.* 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
Guafenesin 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.

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]

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 IFMC to require the skilled nursing care level of care shall be made at an amount equal to the sum of the direct care rate

component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3) plus the non-direct care rate component limit for Medicare-certified hospital-based nursing facilities pursuant to 441—subparagraph 81.6(16) “f”(3), with the rate component limits being revised July 1, 2001, and every second year thereafter. This rate is effective (a) as of the date of notice by IFMC that the lower level of care is required or (b) for the days IFMC 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 IFMC 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 IFMC that the lower level of care is required or (b) for the days IFMC 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 on the “Outpatient/Same Day Surgery List” produced by the Iowa Foundation for Medical Care shall be made only when attending physician has secured approval from the hospital’s utilization review department prior to admittance to the hospital. Approval shall be granted when inpatient care is deemed to be medically necessary based on the condition of the patient or when the surgical procedure is not performed as a routine, primary, independent procedure. The “Outpatient/Same Day Surgery List” shall be published by the department in the provider manuals for hospitals and physicians. The “Outpatient/Same Day Surgery List” shall be developed by the Iowa Foundation for Medical Care, and shall include procedures which can safely and effectively be performed in a doctor’s office or on an outpatient basis in a hospital. The Iowa Foundation for Medical Care may add, delete or modify entries on the “Outpatient/Same Day Surgery List.”

78.3(16) 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.

78.3(17) Rescinded IAB 8/9/89, effective 10/1/89.

78.3(18) Preprocedure review by the IFMC is required if hospitals are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (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]

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. Payment will also be made for the following dental procedures subject to the exclusions for services to adults 21 years of age and older set forth in subrule 78.4(14):

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 physical or mental disability, 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 in a six-month period except for people who need more frequent applications because of physical or mental disability. (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 disability that impairs their ability to maintain adequate oral hygiene. Replacement sealants are covered when medically necessary, as documented in the patient record.

78.4(2) Diagnostic services. Payment shall be made for the following diagnostic services:

a. A comprehensive oral evaluation is payable once per patient per dentist in a three-year period when the patient has not seen that dentist during the three-year period.

b. A periodic oral examination is payable once in a six-month period.

c. A complete mouth radiograph survey consisting of a minimum of 14 periapical films and bite-wing films is a payable service once in a five-year period, except when medically necessary to evaluate development, and to detect anomalies, injuries and diseases. Complete mouth radiograph surveys are not payable under the age of six. A panoramic-type radiography with bitewings is considered the same as a complete 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 when requested by the Iowa Medicaid enterprise medical services unit's dental consultant.

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. Two laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable per member in a 12-month period. Additional laboratory-fabricated crowns using nonprecious materials, other than stainless steel, are payable when prior authorization has been obtained. Noble metals are payable for crowns when members are allergic to all other restorative materials. Stainless steel crowns are payable when a more conservative procedure would not be serviceable. (Cross-reference 78.28(2) "e")

e. Cast post and core, steel post and composite or amalgam in addition to a crown is 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 restorative procedures:

(1) Amalgam or acrylic buildups are considered part of the preparation for the completed restoration.

(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) A two-surface anterior composite restoration will be payable as a one-surface restoration if it involved the lingual surface.

(6) Tooth preparation, temporary restorations, cement bases, pulp capping, impressions, local anesthesia and inhaled 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 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 when prior approval has been received. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (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. A request for approval must be accompanied by a plan for treatment, a completed copy of a periodontal probe chart that exhibits pocket depths, history and radiograph(s). 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 patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.28(2)“a”(2))

d. Pedicle soft tissue graft and free soft tissue graft are payable services with prior approval based on a written narrative describing medical necessity. (Cross-reference 78.28(2)“a”(3))

e. Periodontal maintenance therapy which includes oral prophylaxis, measurement of pocket depths and limited root planing and scaling is a payable service when prior approval has been received. A request for approval must be accompanied by a periodontal treatment plan, a completed copy of a periodontal probe chart which exhibits pocket depths, periodontal history and radiograph(s). Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.28(2)“a”(4))

f. Payment as indicated will be made for the following periodontal services:

(1) Periodontal scaling and root planing, gingivoplasty, osseous surgery will be paid per quadrant.

(2) Gingivoplasty will be paid per tooth.

(3) Osseous allograft will be paid as a single site if one site is involved, or if more than one site is involved, payment will be made for multiple sites.

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 extensive posttreatment restorative procedures are not necessary and when missing teeth do not jeopardize the integrity or function of the dental arches.

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 is payable when prior approval has been received. Payment for 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 will be

approved when nonsurgical treatment has been attempted and a reasonable time 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)“d”)

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, and failure has been demonstrated with a radiograph and narrative history.

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.* General anesthesia, intravenous sedation, and non-intravenous conscious sedation are payable services when the extensiveness of the procedure indicates it or there is a concomitant disease or impairment which warrants its use.
- j.* Routine postoperative care is considered part of the fee for surgical procedures and may not be billed separately.
- k.* 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 and a first-time complete denture including six months’ postdelivery care. An immediate denture and a first-time complete denture are payable when the denture is provided to establish masticatory function. An immediate denture or a first-time complete denture is payable only once following the removal of teeth it replaces. A complete denture is payable only once in a five-year period except when the denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of complete dentures due to resorption in less than a five-year period is not payable.

b. A removable partial denture replacing anterior teeth, including six months’ postdelivery care. A removable partial denture replacing anterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing anterior teeth due to resorption in less than a five-year period is not payable.

c. A removable partial denture replacing posterior teeth including six months’ postdelivery care when prior approval has been received. A removable partial denture replacing posterior teeth shall be

approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.28(2) "c"(1))

d. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth shall be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals shall be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2) "c"(2))

e. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth when prior approval has been received. A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth shall be approved for the member whose medical condition precludes the use of a removable partial denture and who has fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.28(2) "c"(3))

f. Obturator for surgically excised palatal tissue or deficient velopharyngeal function of cleft palate patients.

g. Chairside relines are payable only once per prosthesis every 12 months.

h. Laboratory processed relines are payable only once per prosthesis every 12 months.

i. Tissue conditioning is a payable service twice per prosthesis in a 12-month period.

j. Two repairs per prosthesis in a 12-month period are payable.

k. 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.

l. 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.

78.4(8) Orthodontic procedures. Payment may be made for the following orthodontic procedures:

a. Orthodontic services to treat handicapping malocclusions are payable with prior approval. A score of 26 or above on the index from "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968, is required for approval.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables: degree of malalignment, missing teeth, angle classification, overjet and overbite, openbite, and crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of

the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the Iowa Medicaid enterprise's orthodontic consultant if found to be medically necessary. (Cross-reference 78.28(2)“d”)

b. Space management services shall be payable when there is too little dental ridge to accommodate either the number or the size of teeth and if not corrected significant dental disease will result.

c. Tooth guidance for a limited number of teeth or interceptive orthodontics is a payable service when extensive treatment is not required. Pretreatment records are not required.

78.4(9) *Treatment in a hospital.* Payment will be approved for dental treatment rendered a hospitalized patient only when the mental, physical, or emotional condition of the patient prevents the dentist from providing necessary care in the office.

78.4(10) *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.

78.4(11) *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 exams are not billed for that visit.

78.4(12) *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.

78.4(13) *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 writing prescriptions.

78.4(14) *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]

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 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.

d. Single vision and multifocal lens service, verification and subsequent service. When lenses are necessary, the following enumerated professional and technical optometric services are to be provided:

(1) When 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 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) Protective lenses 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 six years of age.
 3. When there is a prescribed 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.

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 once every 12 months for adults aged 21 and over, except for people with a mental or physical disability.

i. Fitting of contact lenses when required following cataract surgery, documented keratoconus, aphakia, or for treatment of acute or chronic eye disease. Up to eight pairs of contact lenses are allowed for children up to one year of age with aphakia. Up to four pairs of contact lenses per year are allowed for children one to three years of age with aphakia.

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, manufactured by reputable American manufacturers.

b. Standard plastic, plastic and metal combination, or metal frames manufactured by reputable American manufacturers, if available.

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.

a. Materials payable by fee schedule are:

- (1) 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) Protective lenses and safety frames.
- (5) Subnormal visual aids.

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 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.

(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 protective purposes including glasses for eye safety, sunglasses, or glasses with photogray lenses. An exception to this is in 78.6(3) "b"(4).
- c. A second pair of glasses or spare glasses.
- d. Cosmetic surgery and experimental medical and surgical procedures.
- e. Contact lenses if vision is correctable with noncontact lenses except as found at paragraph 78.6(1) "i."

78.6(6) Therapeutically certified optometrists. Therapeutically certified optometrists may provide services and employ pharmaceutical agents in accordance with Iowa Code chapter 154 regulating the practice of optometry. A therapeutically certified optometrist is an optometrist who is licensed to practice optometry in this state and who is certified by the board of optometry to employ the agents and perform the procedures provided by the Iowa Code.

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

[ARC 7548B, IAB 2/11/09, effective 4/1/09]

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-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
307.81	Tension headache	353.0	Brachial plexus lesions	721.7	Traumatic spondylopathy
721.0	Cervical spondylosis without myelopathy	353.1	Lumbosacral plexus lesions	722.0	Displacement of cervical intervertebral disc without myelopathy
721.2	Thoracic spondylosis without myelopathy	353.2	Cervical root lesions, NEC	722.10	Displacement of lumbar intervertebral disc without myelopathy
721.3	Lumbosacral spondylosis without myelopathy	353.3	Thoracic root lesions, NEC	722.11	Displacement of thoracic intervertebral disc without myelopathy
723.1	Cervicalgia	353.4	Lumbosacral root lesions, NEC	722.4	Degeneration of cervical intervertebral disc
724.1	Pain in thoracic spine	353.8	Other nerve root and plexus disorders	722.51	Degeneration of thoracic or thoracolumbar intervertebral disc
724.2	Lumbago	719.48	Pain in joint (other specified sites, must specify site)	722.52	Degeneration of lumbar or lumbosacral intervertebral disc
724.5	Backache, unspecified	720.1	Spinal enthesopathy	722.81	Post laminectomy syndrome, cervical region
784.0	Headache	722.91	Calcification of intervertebral cartilage or disc, cervical region	722.82	Post laminectomy syndrome, thoracic region
		722.92	Calcification of intervertebral cartilage or disc, thoracic region	722.83	Post laminectomy syndrome, lumbar region
		722.93	Calcification of intervertebral cartilage or disc, lumbar region	724.3	Sciatica
		723.0	Spinal stenosis in cervical region		
		723.2	Cervicocranial syndrome		
		723.3	Cervicobrachial syndrome		
		723.4	Brachial neuritis or radiculitis, NOC		
		723.5	Torticollis, unspecified		
		724.01	Spinal stenosis, thoracic region		
		724.02	Spinal stenosis, lumbar region		
		724.4	Thoracic or lumbosacral neuritis or radiculitis		

ICD-9 CATEGORY I	ICD-9 CATEGORY II	ICD-9 CATEGORY III
	724.6 Disorders of sacrum, ankylosis	
	724.79 Disorders of coccyx, coccygodynia	
	724.8 Other symptoms referable to back, facet syndrome	
	729.1 Myalgia and myositis, unspecified	
	729.4 Fascitis, unspecified	
	738.40 Acquired spondylolisthesis	
	756.12 Spondylolisthesis	
	846.0 Sprains and strains of sacroiliac region, lumbosacral (joint; ligament)	
	846.1 Sprains and strains of sacroiliac region, sacroiliac ligament	
	846.2 Sprains and strains of sacroiliac region, sacrospinatus (ligament)	
	846.3 Sprains and strains of sacroiliac region, sacrotuberous (ligament)	
	846.8 Sprains and strains of sacroiliac region, other specified sites of sacroiliac region	
	847.0 Sprains and strains, neck	
	847.1 Sprains and strains, thoracic	
	847.2 Sprains and strains, lumbar	
	847.3 Sprains and strains, sacrum	
	847.4 Sprains and strains, coccyx	

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.

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 62 days thereafter. 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 62 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.

a. Payment shall be made for medical social work services when all of the following conditions are met and the problems are not responding to medical treatment and there does not appear to be a medical reason for the lack of response. The services:

- (1) Are reasonable and necessary to the treatment of a member's illness or injury.
- (2) Contribute meaningfully to the treatment of the member's condition.
- (3) Are under the direction of a physician.
- (4) Are provided by or under the supervision of a qualified medical or psychiatric social worker.
- (5) Address social problems that are impeding the member's recovery.

b. Medical social services directed toward minimizing the problems an illness may create for the member and family, e.g., encouraging them to air their concerns and providing them with reassurance, are not considered reasonable and necessary to the treatment of the patient's illness or injury.

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, hemaplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or mental retardation.

(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 mental retardation.

(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) Mental retardation 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]

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 diagnosis, prognosis, and length of time the item is to be required.

For items requiring prior approval, 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 approval is made on Form 470-0829, Request for Prior Authorization. See rule 441—78.28(249A) for prior approval 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 patient, e.g., elevators, stairway elevators and posture chairs.

e. The amount payable is based on the least expensive item which meets the patient's medical needs. Payment will not be approved for duplicate items.

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 will be maintained on a rental basis for the duration of use.

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.

78.10(2) Durable medical equipment. DME is equipment which 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 will not be provided in a hospital, nursing facility, or intermediate care facility for persons with mental retardation. EXCEPTION: Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility or an intermediate care facility for persons with mental retardation when all of the following requirements and conditions have been met:

(1) A physician's, physician assistant's, or advanced registered nurse practitioner's prescription documents that the member has significant hypoxemia as defined by Medicare and evidenced by supporting medical documentation and the member requires oxygen for 12 hours or more per day for at least 30 days. Oxygen prescribed "PRN" or "as necessary" is not allowed. The documentation maintained in the provider record must contain the following:

1. The number of hours oxygen is required per day;
2. The diagnosis of the disease requiring continuous oxygen, prognosis, and length of time the oxygen will be needed;
3. The oxygen flow rate and concentration; the type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
4. A specific estimate of the frequency and duration of use; and
5. The initial reading on the time meter clock on each concentrator, where applicable.

(2) The maximum Medicaid payment shall be based on the least costly method of oxygen delivery.

(3) Medicaid payment shall be made for the rental of equipment only. All accessories and disposable supplies related to the oxygen delivery system, servicing and repairing of equipment are included in the Medicaid payment.

(4) Oxygen logs must be maintained by the provider. When random postpayment review of these logs indicates less than an average of 12 hours per day of oxygen was provided over a 30-day period, recoupment of the overpayment may occur.

(5) Payment will be made for only one mode of oxygen even if the physician's, physician assistant's, or advanced registered nurse practitioner's prescription allows for multiple modes of delivery.

(6) Payment will not be made for oxygen that is not documented according to department of inspections and appeals 481—subrule 58.21(8).

b. Only the following types of durable medical equipment can be covered through the Medicaid program:

Alternating pressure pump.

Automated medication dispenser. See 78.10(2) "d" for prior authorization requirements.

Bedpan.

Blood glucose monitors, subject to the limitation in 78.10(2) "e."

Blood pressure cuffs.

Cane.

Cardiorespiratory monitor (rental and supplies).
Commode.
Commode pail.
Crutches.
Decubitus equipment.
Dialysis equipment.
Diaphragm (contraceptive device).
Enclosed bed. See 78.10(2) “d” for prior authorization requirements.
Enuresis alarm system (bed-wetting alarm device) for members five years of age or older.
Hospital bed.
Hospital bed accessories.
Inhalation equipment.
Insulin infusion pump. See 78.10(2) “d” for prior authorization requirements.
Lymphedema pump.
Neuromuscular stimulator.
Oximeter.
Oxygen, subject to the limitations in 78.10(2) “a” and 78.10(2) “c.”
Patient lift (Hoyer).
Phototherapy bilirubin light.
Pressure unit.
Protective helmet.
Respirator.
Resuscitator bags and pressure gauge.
Seat lift chair.
Suction machine.
Traction equipment.
Urinal (portable).
Vaporizer.
Ventilator.
Vest airway clearance system. See 78.10(2) “d” for prior authorization requirements.
Walker.
Wheelchair—standard and adaptive.
Whirlpool bath.

c. Coverage of home oxygen equipment and oxygen will be considered reasonable and necessary only for members with significant hypoxemia as defined by Medicare and shown by supporting medical documentation. The physician’s, physician assistant’s, or advanced registered nurse practitioner’s prescription 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 at one year of age and at two years of age and documented in the provider record.

(1) To identify the medical necessity for oxygen therapy, the supplier and a physician, physician assistant, or advanced registered nurse practitioner shall jointly submit Medicare Form B-7401, Physician’s Certification for Durable Medical Equipment, or a reasonable facsimile. The following information is required:

1. A diagnosis of the disease requiring home use of oxygen;
 2. The oxygen flow rate and concentration;
 3. The type of system ordered, i.e., cylinder gas, liquid gas, or concentrator;
 4. A specific estimate of the frequency and duration of use; and
 5. The initial reading on the time meter clock on each concentrator, where applicable.
- Oxygen prescribed “PRN” or “as necessary” is not allowed.

(2) If the patient'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 (doctor of medicine or osteopathy), physician assistant, or advanced registered nurse practitioner of the medical necessity for portable oxygen for specific activities.

(4) Payment for concentrators shall be made only on a rental basis.

(5) All accessories, disposable supplies, servicing, and repairing of concentrators are included in the monthly Medicaid payment for concentrators.

d. Prior authorization is required for the following medical equipment and supplies (Cross-reference 78.28(1)):

(1) Enclosed beds. Payment for an enclosed bed will be approved when prescribed for a patient who meets all of the following conditions:

1. The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

2. The patient's mobility puts the patient at risk for injury.

3. The patient has suffered injuries when getting out of bed.

(2) External insulin infusion pumps. Payment will be approved according to Medicare coverage criteria.

(3) Vest airway clearance systems. Payment will be approved for a vest airway clearance system when prescribed by a pulmonologist for a patient 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 of lung function.

2. The patient 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.

(4) 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 a 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.

(5) Blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. Prior approval shall be granted when the member's medical condition necessitates use of a blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department.

e. Blood glucose monitors are covered through the Medicaid program only if:

(1) The monitor is produced by a manufacturer that has a current agreement to provide a rebate to the department for monitors provided through the Medicaid program; or

(2) Prior authorization based on medical necessity is received pursuant to rule 441—79.8(249A) for a monitor produced by a manufacturer that does not have a current rebate agreement with the department.

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 patient's condition may improve sometime in the future.

a. Prosthetic devices are not covered when dispensed to a patient prior to the time the patient undergoes a procedure which will make necessary the use of the device.

b. Only the following types of prosthetic devices shall be covered through the Medicaid program:

(1) Artificial eyes.

(2) Artificial limbs.

(3) Augmentative communications systems provided for members unable to communicate their basic needs through oral speech or manual sign language. Payment will be made for the most cost-effective item that meets basic communication needs commensurate with the member's cognitive and language abilities. See 78.10(3) "c" for prior approval requirements.

(4) Enteral delivery supplies and products. See 78.10(3) "c" for prior approval requirements.

(5) Hearing aids. See rule 441—78.14(249A).

(6) Oral nutritional products. See 78.10(3) "c" for prior approval requirements. Nutritional products consumed orally are not covered for members in nursing facilities or intermediate care facilities for the mentally retarded.

(7) Orthotic devices. See 78.10(3) "d" for limitations on coverage of cranial orthotic devices.

(8) Ostomy appliances.

(9) 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.

(10) Prosthetic shoes. See rule 441—78.15(249A).

(11) Tracheotomy tubes.

(12) 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. Prior approval is required for the following prosthetic devices:

(1) Augmentative communication systems. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician's, physician assistant's, or advanced registered nurse practitioner's prescription for a particular device shall be submitted to the Iowa Medicaid enterprise medical services unit to request prior approval. Information requested on the prior approval form includes a medical history, diagnosis, and prognosis completed by a physician, physician assistant, or advanced registered nurse practitioner. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status. Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations. The department's consultants with expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department. (Cross-reference 78.28(1) "c")

(2) Enteral products and enteral delivery pumps and supplies. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member's general condition.

A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic or digestive disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

(3) Oral nutritional products. Payment for oral nutritional products shall be approved as medically necessary only 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 the mentally retarded. A request for prior approval shall include a physician's, physician assistant's, or advanced registered nurse practitioner's written order or prescription and documentation to establish the medical necessity for oral supplementation pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member. Examples of conditions that will not justify approval of oral supplementation are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children's program is not available), supplementation to boost calorie or protein intake by less than 51 percent of the daily intake, and the absence of severe pathology of the body or psychological pathology or disorder.

d. 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 photographic evidence supporting moderate to severe nonsynostotic positional plagiocephaly and either:

(1) The member is between 3 and 5 months of age and has failed to respond to a two-month trial of repositioning therapy; or

(2) The member is between 6 and 18 months 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. Only the following types of medical supplies and supplies necessary for the effective use of a payable item can be purchased through the medical assistance program:

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 blood glucose test strips, subject to the limitation in 78.10(4) "c."

Diabetic supplies, other than blood glucose test strips (needles, syringes, and diabetic urine test supplies).

Dialysis supplies.

Diapers (for members aged four and above).

Disposable catheterization trays or sets (sterile).

Disposable irrigation trays or sets (sterile).

Disposable saline enemas (e.g., sodium phosphate type).

Disposable underpads.

Dressings.

Elastic antiembolism support stocking.

Enema.

Hearing aid batteries.

Respirator supplies.

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 the mentally retarded when prescribed by the physician, physician assistant, or advanced registered nurse practitioner:

Catheter (indwelling Foley).

Colostomy and ileostomy appliances.

Colostomy and ileostomy care dressings, liquid adhesive and adhesive tape.

Diabetic supplies (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).

c. Diabetic blood glucose test strips are covered through the Medicaid program only if:

(1) The strips are produced by a manufacturer that has a current agreement to provide a rebate to the department for test strips provided through the Medicaid program, or

(2) Prior authorization is received pursuant to rule 441—79.8(249A) for test strips produced by a manufacturer that does not have a current rebate agreement with the department, based on medical necessity.

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]

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 an Axis I psychological disorder, subject to the limitations in this rule.

78.12(1) Definitions.

“*Axis I disorder*” means a diagnosed mental disorder, except for personality disorders and mental retardation, as set forth in the “Diagnostic and Statistical Manual IV-TR,” Fourth Edition.

“*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 Axis I 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.), an advanced registered nurse practitioner (ARNP), a psychologist, a social worker (LMSW or LISW), a marital and family therapist (LMFT), or a mental health counselor (LMHC) who:

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

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 provided in connection with this rule for members enrolled in the Iowa Plan are covered services under the Iowa Plan pursuant to 441—Chapter 88, Division IV.

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 an Axis I 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]

441—78.13(249A) Nonemergency medical transportation. Nonemergency transportation to receive medical care, including any reimbursement of transportation expenses incurred by a Medicaid member, shall be provided through the broker designated by the department pursuant to a contract between the department and the broker, as specified in this rule.

78.13(1) Member request. When a member needs nonemergency transportation, one way or round trip, to receive medical care provided by the Medicaid program, including any reimbursement of transportation expenses incurred by the member, the member must contact the broker in advance. The broker shall establish and publicize the procedures for members to request transportation services. The broker is required to provide transportation within 72 hours of a request only if receipt of medical care within 72 hours is medically necessary.

78.13(2) Necessary services. Transportation shall be provided only when the member needs transportation to receive necessary services covered by the Iowa Medicaid program from an enrolled provider, including transportation needed to obtain prescribed drugs.

78.13(3) Access to free transportation. Transportation shall be provided only if the member does not have access to transportation that is available at no cost to the member, such as transportation provided by volunteers, relatives, friends, social service agencies, nursing facilities, residential care centers, or any

other source. EXCEPTION: If a prescribed drug is needed immediately, transportation will be provided to obtain the drug even if free delivery is available.

78.13(4) *Closest medical provider.* Transportation beyond 20 miles (one way) shall be provided only to the closest qualified provider unless:

a. The difference between the closest qualified provider and the provider requested by the member is less than 10 miles (one way); or

b. The additional cost of transportation to the provider requested by the member is medically justified based on:

- (1) A previous relationship between the member and the requested provider,
- (2) Prior experience of the member with closer providers, or
- (3) Special expertise or experience of the requested provider.

78.13(5) *Coverage.* Based on the information provided by the member and the provisions of this rule, the broker shall arrange and reimburse for the most economical form of transportation appropriate to the needs of the member.

a. The broker may require that public transportation be used when reasonably available and the member's condition does not preclude its use.

b. The broker may arrange and reimburse for transportation by arranging to reimburse the member for transportation expenses. In that case, the member shall submit transportation expenses to the broker on Form 470-0386, Medical Transportation Claim, or an equivalent electronic form.

c. When a member is unable to travel alone due to age or due to physical or mental incapacity, the broker shall provide for the expenses of an attendant.

d. The broker shall provide for meals, lodging, and other incidental transportation expenses required for the member and for any attendant required due to the age or incapacity of the member in connection with transportation provided under this rule.

78.13(6) *Exceptions for nursing facility residents.*

a. Nonemergency medical transportation for residents of nursing facilities within 30 miles of the nursing facility (one way) shall not be provided through the broker but shall be the responsibility of the nursing facility.

b. Nonemergency medical transportation for residents of nursing facilities beyond 30 miles from the nursing facility (one way) shall be provided through the broker, but the nursing facility shall contact the broker on behalf of the resident.

78.13(7) *Grievances.* Pursuant to its contract with the department, the broker shall establish an internal grievance procedure for members and transportation providers. Members who have exhausted the grievance process may appeal to the department pursuant to 441—Chapter 7 as an “aggrieved person.” For transportation providers, the grievance process shall end with binding arbitration, with a designee of the Iowa Medicaid enterprise as arbitrator.

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

[ARC 8344B, IAB 12/2/09, effective 12/1/09; ARC 8643B, IAB 4/7/10, effective 3/11/10; ARC 8994B, IAB 8/11/10, effective 10/1/10]

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 recipient'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 a recipient residing in a nursing facility or residential care facility are payable when a statement is submitted signed by the facility 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 recipient residing in an intermediate care facility for the mentally retarded since these facilities are responsible for providing or paying for services required by recipients.

(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.

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 Iowa Foundation for Medical Care (IFMC) is required if ambulatory surgical centers are to be reimbursed for certain frequently performed surgical procedures as set forth under subrule 78.1(19). Criteria are available from IFMC, 1776 West Lakes Parkway, West Des Moines, Iowa 50266-8239, or in local hospital utilization review offices. (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]

441—78.27(249A) Home- and community-based habilitation services.

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.

"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.

"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.

"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.

"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.

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 member's case manager has completed an assessment of the member's need for service, and, based on that assessment, the Iowa Medicaid enterprise medical services unit has determined that the member is in need of home- and community-based habilitation services. A member who is not eligible for Medicaid case management services under 441—Chapter 90 shall receive case management as a home- and community-based habilitation service. The designated case manager shall:

(1) Complete a needs-based evaluation that meets the standards for assessment established in 441—subrule 90.5(1) before services begin and annually thereafter.

(2) Use the evaluation results to develop a comprehensive service plan as specified in subrule 78.27(4).

e. *Plan for service.* The department has approved the member's plan for home- and community-based habilitation services. A service plan that has been validated through ISIS shall be considered approved by the department. Home- and community-based habilitation services provided before department 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 case manager shall apply for services on behalf of a member by entering a program request for habilitation services in ISIS. The department shall issue a notice of decision to the applicant when financial eligibility, determination of needs-based eligibility, and approval of the service plan have been completed.

78.27(4) Comprehensive service plan. Individualized, planned, and appropriate services shall be guided by a member-specific comprehensive service 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 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 shall establish an interdisciplinary team for the member. The team shall include the case manager 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 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 service plan and annual updates to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system before services are implemented. Services provided before the approval date are not payable. The written case plan must be completed, signed and dated by the case manager or service worker within 30 calendar days after plan approval.

(10) Any changes to the service plan must be approved by the Iowa Medicaid enterprise in the individualized services information system 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 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 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 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 service 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. Exclusion. 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 habilitation. “Prevocational habilitation” means services that prepare a member for paid or unpaid employment.

a. Scope. Prevocational habilitation services include teaching concepts such as compliance, attendance, task completion, problem solving, and safety. Services are not oriented to a specific job task, but instead are aimed at a generalized result. Services shall be reflected in the member’s comprehensive service plan and shall be directed to habilitative objectives rather than to explicit employment objectives.

b. Setting. Prevocational habilitation services may be provided in a variety of community-based settings based on the individual need of the member. Meals provided as part of these services shall not constitute a full nutritional regimen (three meals per day).

c. Exclusions. Prevocational habilitation payment shall not be made for the following:

- (1) Services that are available 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 for the service under these programs shall be maintained in the file of each member receiving prevocational habilitation 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 prevocational services.

78.27(10) Supported employment habilitation. “Supported employment habilitation” means services associated with maintaining competitive paid employment.

a. Scope. Supported employment habilitation services are intensive, ongoing supports that enable members to perform in a regular work setting. Services are provided to members who need support because of their disabilities and who are unlikely to obtain competitive employment at or above the minimum wage absent the provision of supports. Covered services include:

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

1. Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the member holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member’s service plan. A member may receive two units of job development services during a 12-month period. The activities provided to the member may include job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities; job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy; and customized job development services specific to the member.

2. Employer development services. The focus of employer development services is to support employers in hiring and retaining members in their workforce and to communicate expectations of the employers to the interdisciplinary team described in subrule 78.27(4). Employer development services may be provided only to members who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the member holds for 30 consecutive calendar days or more. Payment for this service may be made only after the member holds the job for 30 days. A member may receive two units of employer development services during a 12-month period if the member is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include: developing relationships with employers and providing leads for individual members when appropriate; job analysis for a specific job; development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities; identifying and arranging reasonable accommodations with the employer; providing disability awareness and training to the employer when it is deemed necessary; and providing technical assistance to the employer regarding the training progress as identified on the member’s customized training plan.

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

applying for a job, including completion of applications or interviews; and work site assessment and job accommodation evaluation.

(2) Supports to maintain employment, including the following services provided to or on behalf of the member:

1. Individual work-related behavioral management.
2. Job coaching.
3. On-the-job or work-related crisis intervention.
4. Assistance in the use of skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
5. Assistance with time management.
6. Assistance with appropriate grooming.
7. Employment-related supportive contacts.
8. On-site vocational assessment after employment.
9. Employer consultation.

b. Setting. Supported employment may be conducted in a variety of settings, particularly work sites where persons without disabilities are employed.

(1) The majority of coworkers at any employment site with more than two employees where members seek, obtain, or maintain employment must be persons without disabilities.

(2) In the performance of job duties at any site where members seek, obtain, or maintain employment, the member must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(3) When services for maintaining employment are provided to members in a teamwork or “enclave” setting, the team shall include no more than eight people with disabilities.

c. Service requirements. The following requirements shall apply to all supported employment services:

(1) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention.

(2) The provider shall provide employment-related adaptations required to assist the member in the performance of the member’s job functions as part of the service.

(3) Community transportation options (such as carpools, coworkers, self or public transportation, families, volunteers) shall be attempted before the service provider provides transportation. When no other resources are available, employment-related transportation between work and home and to or from activities related to employment may be provided as part of the service.

(4) Members may access both services to maintain employment and services to obtain a job for the purpose of job advancement or job change. A member may receive a maximum of three job placements in a 12-month period and a maximum of 40 units per week of services to maintain employment.

d. Exclusions. Supported employment habilitation payment shall not be made for the following:

(1) Services that are available 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 under these programs shall be maintained in the file of each member receiving supported employment services.

(2) Incentive payments 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 or maintaining members in day activity programs, work activity programs, or sheltered workshop programs.

(6) Supports for volunteer work or unpaid internships.

(7) Tuition for education or vocational training.

(8) Individual advocacy that is not member-specific.

78.27(11) Adverse service actions.

a. Denial. Services shall be denied when the department determines that:

- (1) Rescinded IAB 12/29/10, effective 1/1/11.
- (2) The member is not eligible for or in need of home- and community-based habilitation services.
- (3) The service is not identified in the member's comprehensive service plan.
- (4) Needed services are not available or received from qualifying providers, or no qualifying providers are available.
- (5) The member's service needs exceed the unit or reimbursement maximums for a service as set forth in 441—subrule 79.1(2).

(6) 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]

441—78.28(249A) List of medical services and equipment requiring prior approval, preprocedure review or preadmission review.

78.28(1) Services, procedures, and medications prescribed by a physician (M.D. or D.O.) which are subject to prior approval or preprocedure review are as follows or as specified in the preferred drug list published by the department pursuant to Iowa Code Supplement 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. (Cross-reference 78.10(2) “*b*”) 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 a 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.

c. Enteral products and enteral delivery pumps and supplies require prior approval. Daily enteral nutrition therapy shall be approved as medically necessary only for a member who either has a metabolic or digestive disorder that prevents the member from obtaining the necessary nutritional value from usual foods in any form and cannot be managed by avoidance of certain food products or has a severe pathology of the body that does not allow ingestion or absorption of sufficient nutrients from regular food to maintain weight and strength commensurate with the member’s general condition. (Cross-reference 78.10(3) “*c*”(2))

(1) A request for prior approval shall include a physician’s, physician assistant’s, or advanced registered nurse practitioner’s written order or prescription and documentation to establish the medical necessity for enteral products and enteral delivery pumps and supplies pursuant to the above standards. The documentation shall include:

1. A statement of the member’s total medical condition that includes a description of the member’s metabolic or digestive disorder or pathology.
2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member’s nutritional status and indicate that the member’s nutritional needs were not or could not be met by regular food in pureed form.
3. Documentation of the medical necessity for an enteral pump, if the request includes an enteral pump. The information submitted must identify the medical reasons for not using a gravity feeding set.

(2) Examples of conditions that will not justify approval of enteral nutrition therapy are: weight-loss diets, wired-shut jaws, diabetic diets, milk or food allergies (unless the member is under five years of age and coverage through the Women, Infant and Children’s program is not available), and the use of enteral products for convenience reasons when regular food in pureed form would meet the medical need of the member.

(3) Basis of payment for nutritional therapy supplies shall be the least expensive method of delivery that is reasonable and medically necessary based on the documentation submitted.

d. Rescinded IAB 5/11/05, effective 5/1/05.

e. Augmentative communication systems, which are provided to persons unable to communicate their basic needs through oral speech or manual sign language, require prior approval. Form 470-2145, Augmentative Communication System Selection, completed by a speech pathologist and a physician’s prescription for a particular device shall be submitted to request prior approval. (Cross-reference 78.10(3) “*c*”(1))

(1) Information requested on the prior authorization form includes a medical history, diagnosis, and prognosis completed by a physician. In addition, a speech or language pathologist needs to describe current functional abilities in the following areas: communication skills, motor status, sensory status, cognitive status, social and emotional status, and language status.

(2) Also needed from the speech or language pathologist is information on educational ability and needs, vocational potential, anticipated duration of need, prognosis regarding oral communication skills, prognosis with a particular device, and recommendations.

(3) The department’s consultants with an expertise in speech pathology will evaluate the prior approval requests and make recommendations to the department.

f. Preprocedure review by the Iowa Foundation for Medical Care (IFMC) will be required if payment under Medicaid is to be made for certain frequently performed surgical procedures which have

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

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

g. Prior authorization is required for enclosed beds. (Cross-reference 78.10(2)"c") The department shall approve payment for an enclosed bed when prescribed for a patient who meets all of the following conditions:

(1) The patient has a diagnosis-related cognitive or communication impairment that results in risk to safety.

(2) The patient's mobility puts the patient at risk for injury.

(3) The patient has suffered injuries when getting out of bed.

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. Prior authorization is required for oral nutritional products. (Cross-reference 78.10(2)"c") The department shall approve payment for oral nutritional products 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.

(1) A request for prior approval shall include a written order or prescription from a physician, physician assistant, or advanced registered nurse practitioner and documentation to establish the medical necessity for oral nutritional products pursuant to these standards. The documentation shall include:

1. A statement of the member's total medical condition that includes a description of the member's metabolic, digestive, or psychological disorder or pathology.

2. Documentation of the medical necessity for commercially prepared products. The information submitted must identify other methods attempted to support the member's nutritional status and indicate that the member's nutritional needs were not or could not be met by regular food in pureed form.

3. Documentation to support the fact that regular foods will not provide sufficient nutritional value to the member, if the request includes oral supplementation of a regular diet.

(2) Examples of conditions that will not justify approval of oral nutritional products are: weight-loss diets, wired-shut jaws, diabetic diets, and milk or food allergies (unless the member is under five years of age and coverage through the Special Supplemental Nutrition Program for Women, Infants, and Children is not available).

j. Prior authorization is required for vest airway clearance systems. (Cross-reference 78.10(2)"c") The department shall approve payment for a vest airway clearance system when prescribed by a pulmonologist for a patient with a medical diagnosis related to a lung disorder if all of the following conditions are met:

(1) Pulmonary function tests for the 12 months before initiation of the vest demonstrate an overall significant decrease of lung function.

(2) The patient 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.

k. Prior authorization is required for blood glucose monitors and diabetic test strips produced by a manufacturer that does not have a current agreement to provide a rebate to the department for monitors or test strips provided through the Medicaid program. The department shall approve payment when a

blood glucose monitor or diabetic test strips produced by a manufacturer that does not have a current rebate agreement with the department are medically necessary.

78.28(2) Dental services. Dental services which require prior approval are as follows:

a. The following periodontal services:

(1) Payment for periodontal scaling and root planing will be approved when interproximal and subgingival calculus is evident in X-rays or when justified and documented that curettage, scaling or root planing is required in addition to routine prophylaxis. (Cross-reference 78.4(4) “*b*”)

(2) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. Payment for other periodontal surgical procedures will be approved after periodontal scaling and root planing has been provided, a reevaluation examination has been completed, and the patient has demonstrated reasonable oral hygiene, unless the patient is unable to demonstrate reasonable oral hygiene because of physical or mental disability or in cases which demonstrate gingival hyperplasia resulting from drug therapy. (Cross-reference 78.4(4) “*c*”)

(3) Payment for pedicle soft tissue graft and free soft tissue graft will be approved when the written narrative describes medical necessity. (Cross-reference 78.4(4) “*d*”)

(4) Payment for periodontal maintenance therapy may be approved after periodontal scaling and root planing or periodontal surgical procedures have been provided. Periodontal maintenance therapy may be approved once per three-month interval for moderate to advanced cases if the condition would deteriorate without treatment. (Cross-reference 78.4(4) “*e*”)

b. Surgical endodontic treatment which includes 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 will be approved when nonsurgical treatment has been attempted and a reasonable time 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 78.4(5) “*c*”)

c. The following prosthetic services:

(1) A removable partial denture replacing posterior teeth will be approved when the member has fewer than eight posterior teeth in occlusion 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. A removable partial denture replacing posterior teeth is payable only once in a five-year period unless the removable partial denture is broken beyond repair, lost or stolen, or no longer fits due to growth or changes in jaw structure, and is required to prevent significant dental problems. Replacement of a removable partial denture replacing posterior teeth due to resorption in less than a five-year period is not payable. (Cross-reference 78.4(7) “*c*”)

(2) A fixed partial denture (including an acid etch fixed partial denture) replacing anterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing anterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7) “*d*”)

(3) A fixed partial denture (including an acid etch fixed partial denture) replacing posterior teeth will be approved for members whose medical condition precludes the use of a removable partial denture and who have fewer than eight posterior teeth in occlusion or if 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 fixed partial denture brings eight posterior teeth in occlusion, no additional fixed partial denture will be approved. High noble or noble metals will be approved only when the member is allergic to all other restorative materials. A fixed partial denture replacing posterior teeth is payable only once in a five-year period unless the fixed partial denture is broken beyond repair. (Cross-reference 78.4(7) “*e*”)

(4) Dental implants and related services will be authorized 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.

d. Orthodontic services to treat a handicapping malocclusion are payable with prior approval. A score of 26 or above on the index from “Handicapping Malocclusion Assessment to Establish Treatment Priority,” by J. A. Salzman, D.D.S., American Journal of Orthodontics, October 1968, is required for approval.

(1) A handicapping malocclusion is a condition that constitutes a hazard to the maintenance of oral health and interferes with the well-being of the patient by causing impaired mastication, dysfunction of the temporomandibular articulation, susceptibility to periodontal disease, susceptibility to dental caries, and impaired speech due to malpositions of the teeth. Treatment of handicapping malocclusions will be approved only for the severe and the most handicapping. Assessment of the most handicapping malocclusion is determined by the magnitude of the following variables:

1. Degree of malalignment;
2. Missing teeth;
3. Angle classification;
4. Overjet and overbite;
5. Openbite; and
6. Crossbite.

(2) A request to perform an orthodontic procedure must be accompanied by an interpreted cephalometric radiograph and study models trimmed so that the models simulate centric occlusion of the patient. A written plan of treatment must accompany the diagnostic aids. Posttreatment records must be furnished upon request of the Iowa Medicaid enterprise medical services unit.

(3) Approval may be made for eight units of a three-month active treatment period. Additional units may be approved by the department’s orthodontic consultant if the additional units are found to be medically necessary. (Cross-reference 78.4(8) “a”)

e. More than two laboratory-fabricated crowns will be approved in a 12-month period for anterior teeth that cannot be restored with a composite or amalgam restoration and for posterior teeth that cannot be restored with a composite or amalgam restoration or stainless steel crown. (Cross-reference 78.4(3) “d”)

f. Endodontic retreatment of a tooth will be authorized when the conventional treatment has been completed, a reasonable time has elapsed, and failure has been demonstrated with a radiograph and narrative history.

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.

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 preadmission review. Payment for inpatient hospital admissions is approved when it meets the criteria for inpatient hospital care as determined by the IFMC or its delegated hospitals. Criteria are available from IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, or in local hospital utilization review offices. (Cross-reference 441—78.3(249A))

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

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) Rescinded IAB 1/3/96, effective 3/1/96.

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”)

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]

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 Iowa Foundation for Medical Care. 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, bulimia, or bulimarexia. Compulsive overeaters are not acceptable 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 as established by the DSM III R (Diagnostic and Statistical Manual, Third Edition, Revised).

In addition to the diagnostic criteria, the need for treatment will be determined by a demonstrable loss of control of eating behaviors and the failure of the patient in recent attempts at voluntary self-control of the problem. Demonstrable impairment, dysfunction, disruption or harm of physical health, emotional health (e.g., significant depression withdrawal, isolation, suicidal ideas), vocational or educational functioning, or interpersonal functioning (e.g., loss of relationships, legal difficulties) shall have occurred.

The need for treatment may be further substantiated by substance abuse, out-of-control spending, incidence of stealing to support habit, or compulsive gambling.

The symptoms shall have been present for at least six months and three of the following criteria must be present:

Medical criteria including endocrine and metabolic factors (e.g., amenorrhea, menstrual irregularities, decreased reflexes, cold intolerance, hypercarotenemia, parotid gland enlargement, lower respiration rate, hair loss, abnormal cholesterol or triglyceride levels).

Other cardiovascular factors including hypotension, hypertension, arrhythmia, ipecac poisoning, fainting, or bradycardia.

Renal considerations including diuretic abuse, dehydration, elevated BUN, renal calculi, edema, or hypokalemia.

Gastrointestinal factors including sore throats, mallery-weiss tears, decreased gastric emptying, constipation, abnormal liver enzymes, rectal bleeding, laxative abuse, or esophagitis.

Hematologic considerations including anemia, leukopenia, or thrombocytopenia.

Ear, nose, and throat factors including headaches or dizziness.

Skin considerations including lanugo or dry skin.

Aspiration pneumonia, a pulmonary factor.

The presence of severe symptoms and complications as evaluated and documented by the medical director may require a period of hospitalization to establish physical or emotional stability.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on problems and needs identified in the assessment and specifies the regular times at which the plan will be reassessed.

The patient's perceptions of needs and, when appropriate and available, the family's perceptions of the patient's needs shall be documented.

The patient's participation in the development of the treatment plans is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. Plans for discharge shall meet the requirements for discharge plans for alcohol and substance abuse patients in subrule 78.31(3), paragraph "a," subparagraph (6).

(7) Restriction and limitations on payment. Medicaid will pay for a maximum of 30 days of a structured outpatient treatment program. Payment beyond 30 days is made when documentation indicates that the patient has not reached an exit level.

Eating disorder programs will include an aftercare component meeting weekly for at least one year without charge.

Family counseling groups held in conjunction with the eating disorders program will be part of the overall treatment charge.

c. Cardiac rehabilitation.

(1) General characteristics. Cardiac rehabilitation programs shall provide a supportive educational environment in which to facilitate behavior change with respect to the accepted cardiac risk factors, initiate prescribed exercise as a mode of facilitating the return of the patient to everyday activities by improving cardiovascular functional capacity and work performance, and promote a long-term commitment to lifestyle changes that could positively affect the course of the cardiovascular disease process.

(2) Treatment staff. Professional disciplines who must be represented on the treatment staff, either by employment by the facility (full-time or part-time), contract or referral, are as follows:

At least one physician responsible for responding to emergencies must be physically present in the hospital when patients are receiving cardiac rehabilitation services. The physician must be trained and certified at least to the level of basic life support.

A medical consultant shall oversee the policies and procedures of the outpatient cardiac rehabilitation area. The director shall meet with the cardiac rehabilitation staff on a regular basis to review exercise prescriptions and any concerns of the team.

A cardiac rehabilitation nurse shall carry out the exercise prescription after assessment of the patient. The nurse shall be able to interpret cardiac dysrhythmia and be able to initiate emergency action if necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

A physical therapist shall offer expertise in unusual exercise prescriptions where a patient has an unusual exercise problem.

A dietitian shall assess the dietary needs of persons and appropriately instruct them on their prescribed diets.

A social worker shall provide counseling as appropriate and facilitate a spouse support group. A licensed occupational therapist shall be available as necessary.

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, dysrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized.

The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not “covered Part D drugs” as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a “Part D eligible individual” as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient’s condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient’s treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient’s condition.

6. Partial hospitalization and day treatment services to reduce or control a person’s psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person’s level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day. Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient’s response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

(5) Plan of treatment. For each patient there is a written comprehensive and individualized description of treatment to be undertaken. The treatment plan is based on the problems and needs identified in the assessment and specifies the times at which the plan will be reassessed.

The patient's perception of needs and, when appropriate and available, the family's perception of the patient's needs shall be documented.

The patient's participation in the development of the treatment plan is sought and documented.

Each patient is reassessed to determine current clinical problems, needs, and responses to treatment. Changes in treatment are documented.

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. 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]

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 mental retardation, 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]

441—78.34(249A) HCBS ill and handicapped waiver services. Payment will be approved for the following services to clients eligible for HCBS ill and handicapped waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.34(1) Homemaker services. Homemaker services are those services provided when the client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and include:

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 client, and dishes.

c. Rescinded IAB 9/30/92, effective 12/1/92.

d. 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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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 one hour.

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 rule 441—83.1(249A).

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.

78.34(6) *Counseling services.* Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician.

The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

- (8) Colostomy care.

- (9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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 one-hour units 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 one hour.

78.34(9) *Home and vehicle modification.* Covered home and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications.

(1) Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service.

(2) The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

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 ill and handicapped 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).

(3) Schedule the provision of services.

(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.

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]

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 consumers eligible for the HCBS elderly waiver services as established in 441—Chapter 83. The

consumer shall have a billable waiver service each calendar quarter. Services must be billed in whole units.

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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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 client lives alone or when the person who usually performs these functions for the client is incapacitated or occupied providing direct care to the client. A unit of service is one hour. Components of the service include:

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, and washing and mending clothes.

- c. Accompaniment to medical or psychiatric services.
- d. Meal preparation: planning and preparing balanced meals.
- e. Bathing and dressing for self-directing recipients.

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 one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.21(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 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.

78.37(7) *Chore services.* Chore services include the following services: window and door maintenance, such as hanging screen windows and doors, replacing windowpanes, and washing windows; minor repairs to walls, floors, stairs, railings and handles; heavy cleaning which includes cleaning attics or basements to remove fire hazards, moving heavy furniture, extensive wall washing, floor care or painting and trash removal; and yard work such as mowing lawns, raking leaves and shoveling walks. A unit of service is one-half hour.

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 and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and 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 recipients to conduct business errands, essential shopping, to receive medical services not reimbursed through medical transportation, and to reduce social isolation. A unit of service is per mile, per trip, or rate established by area agency on aging.

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 one hour.

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- (8) Colostomy care.
- (9) Care of medical conditions out of control which includes 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.

c. A unit of service provided by an individual or an agency, other than an assisted living program, is 1 hour or one 8- to 24-hour day. When provided by an assisted living program, a unit of service is one calendar month. If services are provided by an assisted living program for less than one full calendar month, the monthly reimbursement rate shall be prorated based on the number of days service is provided. Except for services provided by an assisted living program, each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

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).

(3) Schedule the provision of services.
(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.

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]

441—78.38(249A) HCBS AIDS/HIV waiver services. Payment will be approved for the following services to clients eligible for the HCBS AIDS/HIV waiver services as established in 441—Chapter 83. Services must be billed in whole units.

78.38(1) Counseling services. Counseling services are face-to-face mental health services provided to the client and caregiver by a mental health professional as defined in rule 441—24.61(225C,230A) to facilitate home management of the client 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 client's family or other caregiver to provide care, and for the purpose of helping the client and those caring for the client to adjust to the client's disability or terminal condition. Counseling services may be provided to the client's caregiver only when included in the case plan for the client.

Payment will be made for individual and group counseling. A unit of individual counseling for the waiver client or the waiver client and the client's caregiver is 15 minutes. A unit of group counseling is one hour. 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 client lives alone or when the person who usually performs these functions for the client needs assistance with performing the functions. A unit of service is one hour. Components of the service are directly related to the care of the client and are:

- 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 client, and dishes.
- c.* Accompaniment to medical or psychiatric services or for children aged 18 and under to school.
- d.* 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 one hour.

d. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.41(249A).

e. When respite care is provided, the provision of, or payment for, other duplicative services under the waiver is precluded.

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 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.

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 a half day (1 to 4 hours), a full day (4 to 8 hours), or an extended day (8 to 12 hours). 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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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).

(3) Schedule the provision of services.

(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.

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)]

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. All services include the applicable and necessary instruction, supervision, assistance and support as required by the member in achieving the member's life goals. The services, amount and supports provided under the HCBS intellectual disability waiver shall be delivered in the least restrictive environment and in conformity with the member's service plan. Reimbursement shall not be available under the waiver for any services that the member can obtain through the Medicaid state plan. All services shall be billed in whole units.

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.

(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 an hourly 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) One hour when subparagraph 78.41(1)"f"(1) does not apply.

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

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

(2) 5,110 hourly units are available per state fiscal year except a leap year when 5,124 hourly 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 one hour.

d. Payment for respite services shall not exceed \$7,050 per the member's waiver year.

e. The service shall be identified in the member's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services or with supported community living, nursing, or home health aide services provided through Medicaid or the HCBS intellectual disability waiver.

g. Respite care is not to be provided to members during the hours in which the usual caregiver is employed except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child's day care. Respite cannot be provided to a member whose usual caregiver is a consumer-directed attendant care provider for the member.

h. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.60(249A).

i. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

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

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 and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and 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 individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs “a” and “b” that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or habilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in 441—subrule 83.67(1) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet a person’s employment needs. Second, the consumer’s interdisciplinary team must determine that the identified services are necessary. Third, the consumer’s case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member’s service plan. A consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in 441—subrule 83.67(1). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer’s customized training plan.

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

1. Job opening identification with the consumer.
2. Assistance with applying for a job, including completion of applications or interviews.

3. Work site assessment and job accommodation evaluation.
- b. Supports to maintain employment.
 - (1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:
 1. Individual work-related behavioral management.
 2. Job coaching.
 3. On-the-job or work-related crisis intervention.
 4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
 5. Consumer-directed attendant care services as defined in subrule 78.41(8).
 6. Assistance with time management.
 7. Assistance with appropriate grooming.
 8. Employment-related supportive contacts.
 9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
 10. On-site vocational assessment after employment.
 11. Employer consultation.
 - (2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.
 - (3) A unit of service is one hour.
 - (4) A maximum of 40 units may be received per week.
- c. The following requirements apply to all supported employment services:
 - (1) Employment-related adaptations required to assist the consumer within the performance of the consumer’s job functions shall be provided by the provider as part of the services.
 - (2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.
 - (3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.
 - (4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.
 - (5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.
 - (6) All services shall be identified in the consumer’s service plan maintained pursuant to rule 441—83.67(249A).
 - (7) The following services are not covered:
 1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;
 2. Supports for volunteer work or unpaid internships;
 3. Tuition for education or vocational training; or
 4. Individual advocacy that is not consumer specific.
 - (8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other

Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

- (1) Dressing.
- (2) Bath, shampoo, hygiene, and grooming.
- (3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.
- (4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.
- (5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.
- (6) Housekeeping services which are essential to the member's health care at home.
- (7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.
- (8) Wound care.
- (9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.
- (10) Cognitive assistance with tasks such as handling money and scheduling.
- (11) Fostering communication through interpreting and reading services as well as assistive devices for communication.
- (12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

- (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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.
- (8) Colostomy care.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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 one-hour units 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 one hour.
- 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 receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS intellectual disability waiver supported community living service.

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. A unit of service is a full day (4 to 8 hours) or a half-day (1 to 4 hours) or an extended day (8 to 12 hours).

78.41(13) *Prevocational services.* Prevocational services are services that are aimed at preparing a member for paid or unpaid employment, but that are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities that are not primarily directed at teaching specific job skills but at more generalized habilitative goals, and are reflected in a habilitative plan that focuses on general habilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) that are otherwise available to the member through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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

78.41(14) *Day habilitation services.*

a. *Scope.* Day habilitation services are services that assist or support the consumer in developing or maintaining life skills and community integration. Services must enable or enhance the consumer'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 consumer's home. The unit of service is an hour. The units of services payable are limited to a maximum of 10 hours per month.

c. *Unit of service.* Except as provided in paragraph “b,” the unit of service may be an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

d. Exclusions.

(1) Services shall not be provided in the consumer's home, except as provided in paragraph "b." For this purpose, services provided in a residential care facility where the consumer lives are not considered to be provided in the consumer'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).
- (3) Schedule the provision of services.
- (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.

1. 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.

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]

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 consumers eligible for the HCBS brain injury services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan. The services, amount and supports provided under the HCBS brain injury waiver shall be delivered in the least restrictive environment and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid.

All services shall be billed in whole units.

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 service excludes transportation to and from work or day programs.

(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 an hourly 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) One hour when subparagraph 78.43(2)“e”(1) does not apply.

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

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

(2) 8,395 hourly units are available per state fiscal year except a leap year, when 8,418 hourly 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 one hour.

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. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS brain injury waiver supported community living services, Medicaid nursing, or Medicaid home health aide services.

f. The interdisciplinary team shall determine if the member will receive basic individual respite, specialized respite or group respite as defined in rule 441—83.81(249A).

g. A maximum of 14 consecutive days of 24-hour respite care may be reimbursed.

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

78.43(4) Supported employment services. Supported employment services are individualized services associated with obtaining and maintaining competitive paid employment in the least restrictive environment possible, provided to individuals for whom competitive employment at or above minimum wage is unlikely and who, because of their disability, need intense and ongoing support to perform in a work setting. Individual placements are the preferred service model. Covered services are those listed in paragraphs “a” and “b” that address the disability-related challenges to securing and keeping a job.

a. Activities to obtain a job. Covered services directed to obtaining a job must be provided to or on behalf of a consumer for whom competitive employment is reasonably expected within less than one year. Services must be focused on job placement, not on teaching generalized employment skills or rehabilitative goals. Three conditions must be met before services are provided. First, the consumer and the interdisciplinary team described in rule 441—83.87(249A) must complete the form that Iowa vocational rehabilitation services uses to identify the supported employment services appropriate to meet the consumer's employment needs. Second, the consumer's interdisciplinary team must determine that the identified services are necessary. Third, the consumer's case manager must approve the services. Available components of activities to obtain a job are as follows:

(1) Job development services. Job development services are directed toward obtaining competitive employment. A unit of service is a job placement that the consumer holds for 30 consecutive calendar days or more. Payment is available once the service is authorized in the member's service plan. A

consumer may receive two units of job development services during a 12-month period. The activities provided to the consumer may include:

1. Job procurement training, including grooming and hygiene, application, résumé development, interviewing skills, follow-up letters, and job search activities.
2. Job retention training, including promptness, coworker relations, transportation skills, disability-related supports, job benefits, and an understanding of employee rights and self-advocacy.
3. Customized job development services specific to the consumer.

(2) Employer development services. The focus of employer development services is to support employers in hiring and retaining consumers in their workforce and to communicate expectations of the employers to the interdisciplinary team described in rule 441—83.87(249A). Employer development services may be provided only to consumers who are reasonably expected to work for no more than 10 hours per week. A unit of service is one job placement that the consumer holds for 30 consecutive calendar days or more. Payment for this service may be made only after the consumer holds the job for 30 days. A consumer may receive two units of employer development services during a 12-month period if the consumer is competitively employed for 30 or more consecutive calendar days and the other conditions for service approval are met. The services provided may include:

1. Developing relationships with employers and providing leads for individual consumers when appropriate.
2. Job analysis for a specific job.
3. Development of a customized training plan identifying job-specific skill requirements, employer expectations, teaching strategies, time frames, and responsibilities.
4. Identifying and arranging reasonable accommodations with the employer.
5. Providing disability awareness and training to the employer when it is deemed necessary.
6. Providing technical assistance to the employer regarding the training progress as identified on the consumer's customized training plan.

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

1. Job opening identification with the consumer.
 2. Assistance with applying for a job, including completion of applications or interviews.
 3. Work site assessment and job accommodation evaluation.
 - b. Supports to maintain employment.
- (1) Covered services provided to or on behalf of the consumer associated with maintaining competitive paid employment are the following:
1. Individual work-related behavioral management.
 2. Job coaching.
 3. On-the-job or work-related crisis intervention.
 4. Assisting the consumer to use skills related to sustaining competitive paid employment, including assistance with communication skills, problem solving, and safety.
 5. Consumer-directed attendant care services as defined in subrule 78.43(13).
 6. Assistance with time management.
 7. Assistance with appropriate grooming.
 8. Employment-related supportive contacts.
 9. Employment-related transportation between work and home and to or from activities related to employment and disability. Other forms of community transportation (including car pools, coworkers, self or public transportation, families, and volunteers) must be attempted before transportation is provided as a supported employment service.
 10. On-site vocational assessment after employment.

11. Employer consultation.

(2) Services for maintaining employment may include services associated with sustaining consumers in a team of no more than eight individuals with disabilities in a teamwork or “enclave” setting.

(3) A unit of service is one hour.

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

c. The following requirements apply to all supported employment services:

(1) Employment-related adaptations required to assist the consumer within the performance of the consumer’s job functions shall be provided by the provider as part of the services.

(2) Employment-related transportation between work and home and to or from activities related to employment and disability shall be provided by the provider as part of the services. Other forms of community transportation (car pools, coworkers, self or public transportation, families, volunteers) must be attempted before the service provider provides transportation.

(3) The majority of coworkers at any employment site with more than two employees where consumers seek, obtain, or maintain employment must be persons without disabilities. In the performance of job duties at any site where consumers seek, obtain, or maintain employment, the consumer must have daily contact with other employees or members of the general public who do not have disabilities, unless the absence of daily contact with other employees or the general public is typical for the job as performed by persons without disabilities.

(4) All supported employment services shall provide individualized and ongoing support contacts at intervals necessary to promote successful job retention. Each provider contact shall be documented.

(5) Documentation that services provided are not currently available under a program funded under the Rehabilitation Act of 1973 or Public Law 94-142 shall be maintained in the provider file of each consumer.

(6) All services shall be identified in the consumer’s service plan maintained pursuant to rule 441—83.67(249A).

(7) The following services are not covered:

1. Services involved in placing or maintaining consumers in day activity programs, work activity programs or sheltered workshop programs;

2. Supports for volunteer work or unpaid internships;

3. Tuition for education or vocational training; or

4. Individual advocacy that is not consumer specific.

(8) Services to maintain employment shall not be provided simultaneously with day activity programs, work activity programs, sheltered workshop programs, other HCBS services, or other Medicaid services. However, services to obtain a job and services to maintain employment may be provided simultaneously for the purpose of job advancement or job change.

78.43(5) Home and vehicle modification. Covered home and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker may encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.

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 consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging. Transportation may not be reimbursed simultaneously with HCBS brain injury waiver supported community living service.

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 \$6,060 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 a full day (4 to 8 hours) or a half day (1 to 4 hours) or an extended day (8 to 12 hours). 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 services which are aimed at preparing a member for paid or unpaid employment, but which are not job-task oriented. These services include teaching the member concepts necessary for job readiness, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training.

a. Prevocational services are intended to have a more generalized result as opposed to vocational training for a specific job or supported employment. Services include activities which are not primarily directed at teaching specific job skills but at more generalized rehabilitative goals and are reflected in a rehabilitative plan which focuses on general rehabilitative rather than specific employment objectives.

b. Prevocational services do not include:

(1) Services defined in Section 4(a)(4) of the 1975 amendments to the Education of the Handicapped Act (20 U.S.C. 1404(16) and (17)) which are otherwise available to the member through a state or local education agency, or

(2) Vocational rehabilitation services which are otherwise available to the member through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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

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.

a. The service activities may include helping the member with any of the following nonskilled service activities:

(1) Dressing.

(2) Bath, shampoo, hygiene, and grooming.

(3) Access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. It is recommended that the provider receive certification of training and return demonstration for transferring. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance. It is recommended that the provider receive certification of training and return demonstration for catheter assistance. Certification for this is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. It is recommended the provider successfully complete a medication aide course administered by an area community college.

(8) Wound care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

b. The service activities may include helping the member with any of the following skilled services under the supervision of a licensed nurse or licensed therapist working under the direction of a physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall be paid from private insurance and other third-party payment sources, Medicare, the regular Medicaid program, or the early periodic screening diagnosis and treatment program.

(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, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy.

(9) Care of medical conditions out of control which includes 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.

c. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

d. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency that will provide the components of the attendant care services.

e. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care shall determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care for or on behalf of the member or on behalf of the provider.

g. The member, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed

Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a parent or guardian if the parent or guardian has given advanced direction for the service provision.

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 one-hour units 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 one hour.

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).
- (3) Schedule the provision of services.
- (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.

1. *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.

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]

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 DSM-IV-TR Axis I diagnosis consistent with a severe and persistent mental illness. Members with a primary diagnosis of substance 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]

441—78.46(249A) Physical disability waiver service. Payment shall be approved for the following services to consumers eligible for the HCBS physical disability waiver established in 441—Chapter 83 when identified in the consumer's service plan. All services shall include the applicable and necessary instructions, supervision, assistance and support as required by the consumer in achieving the goals written specifically in the service plan and those delineated in Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. The service shall be delivered in the least restrictive environment consistent with the consumer's needs and in conformity with the consumer's service plan.

Reimbursement shall not be available under the waiver for any services that the consumer can obtain through regular Medicaid or from any other funding source.

All services shall be billed in whole units as specified in the following subrules.

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. The services must be cost-effective and necessary to prevent institutionalization.

a. Providers must demonstrate proficiency in delivery of the services in the member's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training.

(1) All training or experience will be detailed on Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement, which must be reviewed and approved by the service worker for appropriateness of training or experience prior to the provision of services. Form 470-3372 becomes an attachment to and part of the case plan.

(2) The member shall give direction and training for activities which are not medical in nature to maintain independence. Licensed registered nurses and therapists must provide on-the-job training and supervision to the provider for skilled activities listed below and described on Form 470-3372. The training and experience must be sufficient to protect the health, welfare and safety of the member.

b. Nonskilled service activities covered are:

- (1) Help with dressing.
- (2) Help with bath, shampoo, hygiene, and grooming.
- (3) Help with access to and from bed or a wheelchair, transferring, ambulation, and mobility in general. Certification for this is available through the area community colleges.

(4) Toilet assistance, including bowel, bladder, and catheter assistance which includes emptying the catheter bag, collecting a specimen and cleaning the external area around the catheter. Certification of training which includes demonstration of competence for catheter assistance is available through the area community colleges.

(5) Meal preparation, cooking, and assistance with eating but not the cost of meals themselves. Meal preparation and cooking shall be provided only in the member's home.

(6) Housekeeping services which are essential to the member's health care at home.

(7) Help with medications ordinarily self-administered including those ordered by a physician or other qualified health care provider. Certification of training in a medication aide course is available through the area community colleges.

(8) Minor wound care which does not require skilled nursing care.

(9) Assistance needed to go to or return from a place of employment and assistance with job-related tasks while the member is on the job site. The cost of transportation for the member and assistance with understanding or performing the essential job functions are not included in consumer-directed attendant care services.

(10) Cognitive assistance with tasks such as handling money and scheduling.

(11) Fostering communication through interpreting and reading services as well as assistance in use of assistive devices for communication.

(12) Assisting or accompanying a member in using transportation essential to the health and welfare of the member. The cost of the transportation is not included.

c. Skilled service activities covered are the following performed under the supervision of a licensed nurse or licensed therapist working under the direction of a licensed physician. The licensed nurse or therapist shall retain accountability for actions that are delegated. The licensed nurse or therapist shall ensure appropriate assessment, planning, implementation, and evaluation. The licensed nurse or therapist shall make on-site supervisory visits every two weeks with the provider present. The cost of the supervision provided by the licensed nurse or therapist shall not be included in the reimbursement for consumer-directed attendant care services.

(1) Tube feedings of members unable to eat solid foods.

(2) Assistance with intravenous therapy which is 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 bowel and bladder training, range of motion exercises, ambulation training, restorative nursing services, reteaching the activities of daily living, respiratory care and breathing programs, reality orientation, reminiscing therapy, remotivation, and behavior modification.

(8) Colostomy care.

(9) Care of medical conditions such as brittle diabetes and comfort care of terminal conditions.

(10) Postsurgical nurse-delegated activities under the supervision of the registered nurse.

(11) Monitoring medication reactions 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.

d. A unit of service is 1 hour or one 8- to 24-hour day. Each service shall be billed in whole units. The consumer-directed attendant care provider shall complete Form 470-4389, Consumer-Directed Attendant Care (CDAC) Service Record, for each day of service.

e. The member, guardian, or attorney in fact under a durable power of attorney for health care shall:

(1) Select the person or agency that will provide the components of the attendant care services.

(2) Determine the components of the attendant care services to be provided with the person who is providing the services to the member.

f. The service activities shall not include parenting or child care on behalf of the member or on behalf of the provider.

g. The member, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete, sign, and date Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan and kept in the member's records.

h. If the member has a guardian or attorney in fact under a durable power of attorney for health care, the care plan shall address how consumer-directed attendant care services will be monitored to ensure 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.

i. If the member has a guardian or attorney in fact under a durable power of attorney for health care, 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.

j. The frequency or intensity of services shall be indicated in the service plan.

k. Consumer-directed attendant care services may not be simultaneously reimbursed with any other HCBS waiver services.

l. Consumer-directed attendant care services may be provided to a recipient of in-home health-related care services, but not at the same time.

m. Services may be provided in the absence of a guardian if the guardian has given advanced direction for the service provision.

78.46(2) Home and vehicle modification. Covered home and 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 and vehicle modification provider. If applicable, payment will be forwarded to the subcontracting agency by the enrolled home and vehicle modification provider following completion of the approved modifications. Payment of up to \$6,060 per year may be made to certified providers upon satisfactory completion of the service. The case manager or service worker shall encumber a portion of the cost of a modification every month within the monthly dollar cap allowed for the member until the entire cost of the modification is encumbered within a consecutive 12-month period.
- 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 \$6,060 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).

78.46(5) Transportation. Transportation services may be provided for consumers to conduct business errands and essential shopping, to receive medical services when not reimbursed through Medicaid as medical transportation, to travel to and from work or day programs, and to reduce social isolation. A unit of service is either per mile, per trip, or the unit established by an area agency on aging.

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).

(3) Schedule the provision of services.

(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.
 1. *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.

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]

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) Rehabilitation services for adults with chronic mental illness. Rescinded IAB 8/1/07, effective 9/5/07.

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 consumers eligible for the HCBS children's mental health waiver as established in 441—Chapter 83. All services shall be provided in accordance with the general standards in subrule 78.52(1), as well as standards provided specific to each waiver service in subrules 78.52(2) through 78.52(5).

78.52(1) General service standards. All children's mental health waiver services shall be provided in accordance with the following standards:

a. Services must be based on the consumer's needs as identified in the consumer's service plan developed pursuant to 441—83.127(249A).

(1) Services must be delivered in the least restrictive environment consistent with the consumer's needs.

(2) Services must include the applicable and necessary instruction, supervision, assistance and support as required by the consumer to achieve the consumer's goals.

b. Payment for services shall be made only upon departmental approval of the services. Waiver services provided before approval of the consumer's eligibility for the waiver shall not be paid.

c. Services or service components must not be duplicative.

(1) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through the Iowa Medicaid program outside of the waiver.

(2) Reimbursement shall not be available under the waiver for any services that the consumer may obtain through natural supports or community resources.

(3) Services may not be simultaneously reimbursed for the same period as nonwaiver Medicaid services or other Medicaid waiver services.

(4) Costs for waiver services are not reimbursable while the consumer is in a medical institution.

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 consumer and the consumer's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the consumer's and the family's social and emotional strength.

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

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

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

- (1) Developing and maintaining a crisis support network for the consumer and for the consumer's family.
- (2) Modeling and coaching effective coping strategies for the consumer's family members.
- (3) Building resilience to the stigma of serious emotional disturbance for the consumer and the family.
- (4) Reducing the stigma of serious emotional disturbance by the development of relationships with peers and community members.
- (5) Modeling and coaching the strategies and interventions identified in the consumer's crisis intervention plan as defined in 441—24.1(225C) for life situations with the consumer's family and in the community.
- (6) Developing medication management skills.
- (7) Developing personal hygiene and grooming skills that contribute to the consumer's positive self-image.
- (8) Developing positive socialization and citizenship skills.

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

(1) The interdisciplinary team must identify the transportation or therapeutic resource as a support need.

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

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

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

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

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

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

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

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 consumer care.

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

78.52(4) *In-home family therapy.* In-home family therapy provides skilled therapeutic services to the consumer 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 consumer 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 one hour. Any period less than one hour shall be prorated.

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

a. Respite care shall not be provided to members during the hours in which the usual caregiver is employed, except when the member is attending a 24-hour residential camp. Respite care shall not be used as a substitute for a child’s day care.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

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

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

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

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

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

e. Respite services provided outside the member’s home shall not be reimbursable if the living unit where respite care is provided is reserved for another person on a temporary leave of absence.

f. A unit of service is one hour.

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]

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. 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 has at least two chronic conditions or has one chronic condition and is at risk of having a second chronic condition. For purposes of this rule, the term "chronic condition" means:

- a.* A mental health disorder.
- b.* A substance use disorder.

- c. Asthma.
- d. Diabetes.
- e. Heart disease.
- f. 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.
- g. Hypertension.

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.

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◇ Two or more ARCs

- ¹ Effective date of 78.3 and 78.31 delayed 70 days by the Administrative Rules Review Committee at its January 1, 1988 meeting.
- ² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting.
- ³ 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.
- ⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.
- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of 12/15/02 delayed 70 days by the Administrative Rules Review Committee at its December 10, 2002, meeting.
- ⁷ 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.
- ⁸ 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.

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 20 percent of other costs.
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 2.5 percent.

f. Contractual rate. Providers are reimbursed on a basis of costs incurred pursuant to a contract between the provider and subcontractor.

g. Retrospectively adjusted prospective rates. Critical access hospitals are reimbursed prospectively, with retrospective adjustments based on annual cost reports submitted by the hospital at the end of the hospital’s fiscal year. The retroactive adjustment equals the difference between the reasonable costs of providing covered services to eligible fee-for-service Medicaid members (excluding members in managed care), determined in accordance with Medicare cost principles, and the Medicaid reimbursement received. Amounts paid that exceed reasonable costs shall be recovered by the department. See paragraphs 79.1(5) “aa” and 79.1(16) “h.”

h. Indian health service 638 facilities. Indian health service 638 facilities as defined at rule 441—77.45(249A) are paid a special daily base encounter rate for all Medicaid-covered services rendered to American Indian or Alaskan native persons who are Medicaid-eligible. This rate is updated periodically and published in the Federal Register after being approved by the Office of Management and Budget. Indian health service 638 facilities may bill only one charge per patient per day for services provided to American Indians or Alaskan natives, which shall include all services provided on that day.

Services provided to Medicaid recipients who are not American Indians or Alaskan natives will be paid at the fee schedule allowed by Iowa Medicaid for the services provided and will be billed separately by CPT code on the CMS-1500 Health Insurance Claim Form. Claims for services provided to Medicaid recipients who are not American Indians or Alaskan natives must be submitted by the individual practitioner enrolled in the Iowa Medicaid program, but may be paid to the facility if the provider agreement so stipulates.

79.1(2) *Basis of reimbursement of specific provider categories.*

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 11/30/09 less 5%. Air ambulance: Fee schedule in effect 11/30/09 less 5%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 11/30/09 less 5%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Assertive community treatment	Fee schedule	\$50.57 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 11/30/09 less 5%.
Behavioral health intervention	Fee schedule as determined by the Iowa Plan for Behavioral Health	Fee schedule in effect 7/1/11.
Behavioral health services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Birth centers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Chiropractors	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 11/30/09 less 2.5%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 11/30/09 less 5%.
Family planning clinics	Fee schedule	Fee schedule in effect 1/31/10.
Federally qualified health centers	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in “2” below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
<p>HCBS waiver service providers, including:</p> <p>1. Adult day care</p>	Fee schedule	<p>3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.</p> <p>Except as noted, limits apply to all waivers that cover the named provider.</p> <p>For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers effective 7/1/11: Provider's rate in effect 11/30/09. If no 11/30/09 rate: Veterans Administration contract rate or \$22.12 per half-day, \$44.03 per full day, or \$66.03 per extended day if no Veterans Administration contract.</p> <p>For intellectual disability waiver: County contract rate or, effective 7/1/11 in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, \$29.47 per half-day, \$58.83 per full day, or \$75.00 per extended day.</p>
<p>2. Emergency response system:</p> <p> Personal response system</p>	Fee schedule	<p>Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Initial one-time fee: \$49.53. Ongoing monthly fee: \$38.52.</p>
<p> Portable locator system</p>	Fee schedule	<p>Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: One equipment purchase: \$307.69. Initial one-time fee: \$49.53. Ongoing monthly fee: \$38.52.</p>
<p>3. Home health aides</p>	Retrospective cost-related	<p>For AIDS/HIV, elderly, and ill and handicapped waivers effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09.</p> <p>For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.</p>
<p>4. Homemakers</p>	Fee schedule	<p>Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$19.81 per hour.</p>

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
5. Nursing care	For elderly and intellectual disability waivers: Fee schedule as determined by Medicare.	For elderly waiver effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$82.92 per visit. For intellectual disability waiver effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
	For AIDS/HIV and ill and handicapped waivers: Agency's financial and statistical cost report and Medicare percentage rate per visit.	For AIDS/HIV and ill and handicapped waivers effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$82.92 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 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed \$296.94 per day.
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate, not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$33.75 per hour not to exceed \$296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$18.01 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$33.75 per hour not to exceed \$296.94 per day.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$18.01 per hour not to exceed \$296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed the facility's daily Medicaid rate for skilled nursing level of care.
Nursing facility	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed the facility's daily Medicaid rate.
Camps	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed \$296.94 per day.
Adult day care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed the facility's daily Medicaid rate.
Residential care facilities for persons with mental retardation	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed contractual daily rate.
Foster group care	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed daily rate for child welfare services.
Child care facilities	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour not to exceed contractual daily rate.
7. Chore service	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$7.71 per half hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
8. Home-delivered meals	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$7.71 per meal. Maximum of 14 meals per week.
9. Home and vehicle modification	Fee schedule. See 79.1(17)	For elderly waiver: \$1,010 lifetime maximum. For intellectual disability waiver: \$5,050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: \$6,060 per year.
10. Mental health outreach providers	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: \$8.25 per unit.
13. Assistive devices	Fee schedule. See 79.1(17)	Effective 7/1/11: \$110.05 per unit.
14. Senior companion	Fee schedule	Effective 7/1/11 for non-county contract: Provider's rate in effect 11/30/09. If no 11/30/09 rate: \$6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by member and provider	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$20.20 per hour not to exceed \$116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by member and provider	Provider's rate in effect 11/30/09. If no 11/30/09 rate: \$1,300 per calendar month. When prorated per day for a partial month, \$42.74 per day.
Individual	Fee agreed upon by member and provider	Effective July 1, 2010, \$13.47 per hour not to exceed \$78.56 per day.
16. Counseling		
Individual:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$10.79 per unit.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Group:	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$43.14 per hour.
17. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	For brain injury waiver: Retrospective cost-settled rate. For elderly waiver: Quarterly revision of reimbursement rate as necessary to maintain projected expenditures within the amounts budgeted under the appropriations made for the medical assistance program for the fiscal year.
18. Supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: \$34.98 per hour, \$78.88 per day not to exceed the maximum daily ICF/MR rate.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: \$34.98 per hour. Maximum of 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: \$34.98 per hour for all activities other than personal care and services in an enclave setting. \$19.81 per hour for personal care. \$6.19 per hour for services in an enclave setting. \$2,883.71 per month for total service. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule. See 79.1(17)	\$6,060 per year.
21. Behavioral programming	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$43.14 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
23. Prevocational services	Fee schedule	For the brain injury waiver effective 7/1/11: \$48.22 per day, \$24.11 per half-day, or \$13.21 per hour. For the intellectual disability waiver effective 7/1/11: County contract rate or, in absence of a contract rate, \$48.22 per day, \$24.11 per half-day, or \$13.21 per hour.
24. Interim medical monitoring and treatment:		
Home health agency (provided by home health aide)	Cost-based rate for home health aide services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Effective 7/1/11: Lesser of maximum Medicare rate in effect 11/30/09 or maximum Medicaid rate in effect 11/30/09, converted to an hourly rate.
Child development home or center	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.12 per hour.
Supported community living provider	Retrospectively limited prospective rate	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$34.98 per hour, not to exceed the maximum ICF/MR rate per day.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11: The maximum ICF/MR rate per day.
26. Day habilitation	Fee schedule	Effective 7/1/11: County contract rate or, in the absence of a contract rate, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule. See 79.1(17)	\$6,060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$34.98 per hour.
29. In-home family therapy	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$93.63 per hour.
30. Financial management services	Fee schedule	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$65.65 per enrolled member per month.
31. Independent support broker	Rate negotiated by member	Effective 7/1/11, provider's rate in effect 11/30/09. If no 11/30/09 rate: \$15.15 per hour.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
32. Self-directed personal care	Rate negotiated by member	Determined by member's individual budget.
33. Self-directed community supports and employment	Rate negotiated by member	Determined by member's individual budget.
34. Individual-directed goods and services	Rate negotiated by member	Determined by member's individual budget.
Health home services provider	Fee schedule based on number of member's chronic conditions (not including conditions for which member is only at risk). Submission of the per-member per-month (PMPM) claim from the provider confirms that health home services are being provided.	Monthly fee schedule amount.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Home- and community-based habilitation services:		
1. Case management	Fee schedule with cost settlement. See 79.1(1) "d."	Retrospective cost-settled rate.
2. Home-based habilitation	Retrospective cost-related. See 79.1(24)	\$46.70 per hour or \$105.97 per day.
3. Day habilitation	Retrospective cost-related. See 79.1(24)	\$13.21 per hour, \$32.15 per half-day, or \$64.29 per day.
4. Prevocational habilitation	Retrospective cost-related. See 79.1(24)	\$9.91 per hour, \$24.11 per half-day, or \$48.22 per day.
5. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Employer development	Fee schedule	\$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospective cost-related. See 79.1(24)	Maximum of \$34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospective cost-related. See 79.1(24)	\$6.19 per hour for services in an enclave setting; \$19.81 per hour for personal care; and \$34.98 per hour for all other services. Total not to exceed \$2,883.71 per month. Maximum of 40 units per week.
Home health agencies		
1. Skilled nursing, physical therapy, occupational therapy, home health aide, and medical social services; home health care for maternity patients and children	Retrospective cost-related	Lesser of maximum Medicare rate in effect 6/30/12 or maximum Medicaid rate in effect 6/30/12 plus 2%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost-related settlement	Medicaid rate in effect 6/30/12 plus 2%.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
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 11/30/09 less 5%.
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 11/30/09 less 5%.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule less 5%. See 79.1(6)
Indian health service 638 facilities	1. Base rate as determined by the United States Office of Management and Budget for outpatient visits for American Indian and Alaskan native members. 2. Fee schedule for service provided for all other Medicaid members.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate. 2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for the mentally retarded	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 11/30/09 less 5%.
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 11/30/09 less 5%.
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	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16) "f." The direct care rate component limit under 441—81.6(16) "f"(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16) "f"(1) and (2) is 110% of the patient-day-weighted median.

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
	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.	
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 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”(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	Fee schedule in effect 11/30/09 less 5%.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 11/30/09 less 5%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).

<u>Provider category</u>	<u>Basis of reimbursement</u>	<u>Upper limit</u>
Pharmacy administration of influenza vaccine to children	Physician fee schedule for immunization administration	Fee schedule in effect 11/30/09 less 5%.
Physical therapists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7) "a"	Fee schedule in effect 11/30/09 less 5%.
Anesthesia services	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Physician-administered drugs	Fee schedule	Fee schedule in effect 6/30/12 less 2%.
Podiatrists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Prescribed drugs	See 79.1(8)	\$6.20 dispensing fee effective 8/1/11. (See 79.1(8) "a," "b," and "e.")
Psychiatric medical institutions for children		
1. Inpatient	Retrospective cost-related	Effective 8/1/11: Actual and allowable cost not to exceed a maximum for non-state-owned providers of 103% of patient-day-weighted average costs of non-state-owned providers located within Iowa.
2. Outpatient day treatment	Fee schedule	Effective 8/1/11: Fee schedule in effect 11/30/09.
Psychologists	Fee schedule	Fee schedule in effect 11/30/09 less 5%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule less 5%; refer to 79.1(21).
Remedial services	Retrospective cost-related. See 79.1(23)	110% of average cost less 5%.
Rural health clinics	Retrospective cost-related. See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an RHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
Screening centers	Fee schedule	Reimbursement rate for center in effect 11/30/09 less 5%.
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.

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.

“Cost outlier” shall mean cases which have an extraordinarily high cost as established in 79.1(5) “f,” so as to be eligible for additional payments above and beyond the initial DRG payment.

“Critical access hospital” or *“CAH”* means a hospital licensed as a critical access hospital by the department of inspections and appeals pursuant to rule 481—51.52(135B).

“Diagnosis-related group (DRG)” shall mean a group of similar diagnoses combined based on patient age, procedure coding, comorbidity, and complications.

“Direct medical education costs” shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an inpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base year cost reports and is inflated and case-mix adjusted in determining the direct medical education rate. Payment for direct medical education costs shall be made from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims.

For purposes of calculating the disproportionate share rate only, separate direct medical education costs shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using only costs associated with the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Direct medical education rate” shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by inflation factors. The result is divided by the hospital’s case-mix index, then is further divided by net discharges.

For purposes of calculating the disproportionate share rate only, a separate direct medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the direct medical education costs, case-mix index, and net discharges of the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share payment” shall mean a payment that shall compensate for treatment of a disproportionate share of poor patients. On or after July 1, 1997, the disproportionate share payment shall be made directly from the graduate medical education and disproportionate share fund and shall not be added to the reimbursement for claims with discharge dates on or after July 1, 1997.

“Disproportionate share percentage” shall mean either (1) the product of 2½ percent multiplied by the number of standard deviations by which the hospital’s own Medicaid inpatient utilization rate exceeds the statewide mean Medicaid inpatient utilization rate for all hospitals, or (2) 2½ percent. (See 79.1(5) “y”(7).)

A separate disproportionate share percentage shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital, using the Medicaid inpatient utilization rate for children under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

“Disproportionate share rate” shall mean the sum of the blended base amount, blended capital costs, direct medical education rate, and indirect medical education rate multiplied by the disproportionate share percentage.

“DRG weight” shall mean a number that reflects relative resource consumption as measured by the relative charges by hospitals for cases associated with each DRG. That is, the Iowa-specific DRG weight reflects the relative charge for treating cases classified in a particular DRG compared to the average charge for treating all Medicaid cases in all DRGs in Iowa hospitals.

“Final payment rate” shall mean the aggregate sum of the two components (the blended base amount and capital costs) that, when added together, form the final dollar value used to calculate each provider’s reimbursement amount when multiplied by the DRG weight. These dollar values are displayed on the rate table listing.

“Full DRG transfer” shall mean that a case, coded as a transfer to another hospital, shall be considered to be a normal claim for recalibration or rebasing purposes if payment is equal to or greater than the full DRG payment.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated in July of every third year.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct and indirect costs associated with the operation of graduate medical education programs and the costs associated with the treatment of a disproportionate share of poor, indigent, nonreimbursed or nominally reimbursed patients for inpatient services.

“Indirect medical education rate” shall mean a rate calculated as follows: The statewide average case-mix adjusted operating cost per Medicaid discharge, divided by two, is added to the statewide average capital costs, divided by two. The resulting sum is then multiplied by the ratio of the number of full-time equivalent interns and residents serving in a Medicare-approved hospital teaching program divided by the number of beds included in hospital departments served by the interns’ and residents’ program, and is further multiplied by 1.159.

For purposes of calculating the disproportionate share rate only, a separate indirect medical education rate shall be determined for any hospital that qualifies for a disproportionate share payment only as a children’s hospital based on a distinct area or areas serving children, using the number of full-time equivalent interns and residents and the number of beds in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

“Inlier” shall mean those cases where the length of stay or cost of treatment falls within the actual calculated length of stay criteria, or the cost of treating a patient is within the cost boundaries of a DRG payment.

“Long stay outlier” shall mean cases which have an associated length of stay that is greater than the calculated length of stay parameters as defined within the length of stay calculations for that DRG. Payment is as established in 79.1(5) “f.”

“Low-income utilization rate” shall mean the ratio of gross billings for all Medicaid, bad debt, and charity care patients, including billings for Medicaid enrollees of managed care organizations and primary care case management organizations, to total billings for all patients. Gross billings do not include cash subsidies received by the hospital for inpatient hospital services except as provided from state or local governments.

A separate low-income utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only billings for patients under 18 years of age at the time of admission in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

"Medicaid claim set" means the hospital's applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

"Medicaid inpatient utilization rate" shall mean the number of total Medicaid days, including days for Medicaid enrollees of managed care organizations and primary care case management organizations, both in-state and out-of-state, and Iowa state indigent patient days divided by the number of total inpatient days for both in-state and out-of-state recipients. Children's hospitals, including hospitals qualifying for disproportionate share as a children's hospital, receive twice the percentage of inpatient hospital days attributable to Medicaid patients.

A separate Medicaid inpatient utilization rate shall be determined for any hospital qualifying or seeking to qualify for a disproportionate share payment as a children's hospital, using only Medicaid days, Iowa state indigent patient days, and total inpatient days attributable to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

"Neonatal intensive care unit" shall mean a designated level II or level III neonatal unit.

"Net discharges" shall mean total discharges minus transfers and short stay outliers.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; appropriateness of admission, discharge and transfer; and appropriateness of prospective payment outlier cases. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rate table listing" shall mean a schedule of rate payments for each provider. The rate table listing is defined as the output that shows the final payment rate by hospital before being multiplied by the appropriate DRG weight.

"Rebasing" shall mean the redetermination of the blended base amount or other applicable components of the final payment rate from more recent Medicaid cost report data.

"Rebasing implementation year" means 2008 and every three years thereafter.

"Recalibration" shall mean the adjustment of all DRG weights to reflect changes in relative resource consumption.

"Short stay day outlier" shall mean cases which have an associated length of stay that is less than the calculated length of stay parameters as defined within the length of stay calculations. Payment rates are established in 79.1(5) "f."

b. *Determination of final payment rate amount.* The hospital DRG final payment amount reflects the sum of inflation adjustments to the blended base amount plus an add-on for capital costs. This blended base amount plus the add-on is multiplied by the set of Iowa-specific DRG weights to establish a rate schedule for each hospital. Federal DRG definitions are adopted except as provided below:

(1) Substance abuse units certified pursuant to 79.1(5) "r." Three sets of DRG weights are developed for DRGs concerning rehabilitation of substance abuse patients. The first set of weights is developed from charges associated with treating adults in certified substance abuse units. The second set of weights reflects charges associated with treating adolescents in mixed-age certified substance abuse units. The third set of weights reflects charges associated with treating adolescents in designated adolescent-only certified substance abuse units.

Hospitals with these units are reimbursed using the weight that reflects the age of each patient. Out-of-state hospitals may not receive reimbursement for the rehabilitation portion of substance abuse treatment.

(2) Neonatal intensive care units certified pursuant to 79.1(5) "r." Three sets of weights are developed for DRGs concerning treatment of neonates. One set of weights is developed from charges associated with treating neonates in a designated level III neonatal intensive care unit for some portion of their hospitalization. The second set of weights is developed from charges associated with treating

neonates in a designated level II neonatal intensive care unit for some portion of their hospitalization. The third set of weights reflects charges associated with neonates not treated in a designated level II or level III setting. Hospitals are reimbursed using the weight that reflects the setting for neonate treatment.

(3) Psychiatric units. Rescinded IAB 8/29/07, effective 8/10/07.

c. Calculation of Iowa-specific weights and case-mix index. From the Medicaid claim set, the recalibration for rates effective October 1, 2008, will use all normal inlier claims, discard short stay outliers, discard transfers where the final payment is less than the full DRG payment, include transfers where the full payment is greater than or equal to the full DRG payment, and use only the estimated charge for the inlier portion of long stay outliers and cost outliers for weighting calculations. These are referred to as trimmed claims.

(1) Iowa-specific weights are calculated with Medicaid charge data from the Medicaid claim set using trimmed claims. Medicaid charge data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in calculating Iowa-specific weights. One weight is determined for each DRG with noted exceptions. Weights are determined through the following calculations:

1. Determine the statewide geometric mean charge for all cases classified in each DRG.
2. Compute the statewide aggregate geometric mean charge for each DRG by multiplying the statewide geometric mean charge for each DRG by the total number of cases classified in that DRG.
3. Sum the statewide aggregate geometric mean charges for all DRGs and divide by the total number of cases for all DRGs to determine the weighted average charge for all DRGs.
4. Divide the statewide geometric mean charge for each DRG by the weighted average charge for all DRGs to derive the Iowa-specific weight for each DRG.
5. Normalize the weights so that the average case has a weight of one.

(2) The hospital-specific case-mix index is computed by taking each hospital's trimmed claims that match the hospital's base year cost reporting period, summing the assigned DRG weights associated with those claims and dividing by the total number of Medicaid claims associated with that specific hospital for that period. Case-mix indices are not computed for hospitals receiving reimbursement as critical access hospitals.

(3) For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix index shall be computed for any hospital that qualifies for a disproportionate share payment only as a children's hospital. The computation shall use only claims and associated DRG weights for services provided to patients under 18 years of age at the time of admission in all distinct areas of the hospital where services are provided predominantly to children under 18 years of age.

d. Calculation of blended base amount. The DRG blended base amount reflects a 50/50 blend of statewide and hospital-specific base amounts.

(1) Calculation of statewide average case-mix-adjusted cost per discharge. The statewide average cost per discharge is calculated by subtracting from the statewide total Iowa Medicaid inpatient expenditures:

1. The total calculated dollar expenditures based on hospitals' base-year cost reports for capital costs and medical education costs, and
2. The actual payments made for additional transfers, outliers, physical rehabilitation services, psychiatric services rendered on or after October 1, 2006, and indirect medical education.

Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average cost per discharge. The remaining amount (which has been case-mix adjusted and adjusted to reflect inflation if applicable) is divided by the statewide total number of Iowa Medicaid discharges reported in the Medicaid management information system (MMIS) less an actual number of nonfull DRG transfers and short stay outliers.

(2) Calculation of hospital-specific case-mix-adjusted average cost per discharge. The hospital-specific case-mix-adjusted average cost per discharge is calculated by subtracting from the lesser of total Iowa Medicaid costs or covered reasonable charges, as determined by the hospital's base-year cost report or MMIS claims system, the actual dollar expenditures for capital costs,

direct medical education costs, and the payments made for nonfull DRG transfers, outliers, physical rehabilitation services, and psychiatric services rendered on or after October 1, 2006, if applicable. The remaining amount is case-mix adjusted, multiplied by inflation factors, and divided by the total number of Iowa Medicaid discharges from the MMIS claims system for that hospital during the applicable base year, less the nonfull DRG transfers and short stay outliers.

For purposes of calculating the disproportionate share rate only, a separate hospital-specific case-mix-adjusted average cost per discharge shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the costs, charges, expenditures, payments, discharges, transfers, and outliers attributable to the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(3) Calculation of the blended statewide and hospital-specific base amount. The hospital-specific case-mix adjusted average cost per discharge is added to the case-mix adjusted statewide average cost per discharge and divided by two to arrive at a 50/50 blended base amount.

e. Add-ons to the base amount.

(1) One payment for capital costs is added on to the blended base amount.

Capital costs are included in the rate table listing and added to the blended base amount before the final payment rate schedule is set. This add-on reflects a 50/50 blend of the statewide average case-mix-adjusted capital cost per discharge and the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients.

Allowable capital costs are determined by multiplying the capital amount from the base-year cost report by 80 percent. Cost report data for hospitals receiving reimbursement as critical access hospitals during any of the period of time included in the base-year cost report is not used in calculating the statewide average case-mix-adjusted capital cost per discharge.

The 50/50 blend is calculated by adding the case-mix-adjusted hospital-specific per discharge capital cost to the statewide average case-mix-adjusted per discharge capital costs and dividing by two. Hospitals whose blended capital add-on exceeds one standard deviation off the mean Medicaid blended capital rate will be subject to a reduction in their capital add-on to equal the first standard deviation.

For purposes of calculating the disproportionate share rate only, a separate add-on to the base amount for capital costs shall be calculated for any hospital that qualifies for a disproportionate share payment only as a children's hospital based on a distinct area or areas serving children, using the case-mix-adjusted hospital-specific base-year capital cost per discharge attributed to Iowa Medicaid patients in the distinct area or areas in the hospital where services are provided predominantly to children under 18 years of age.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

f. Outlier payment policy. Additional payment is made for approved cases meeting or exceeding Medicaid criteria for day and cost outliers for each DRG. Effective for claims with dates of services ending July 1, 1993, and after, 100 percent of outlier costs will be paid to facilities at the time of claim reimbursement. The QIO shall perform retrospective outlier reviews in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa.

(1) Long stay outliers. Long stay outliers are incurred when a patient's stay exceeds the upper day limit threshold. This threshold is defined as the lesser of the arithmetically calculated average length of stay plus 23 days of care or two standard deviations above the average statewide length of stay for a given DRG, calculated geometrically. Reimbursement for long stay outliers is calculated at 60 percent of the average daily rate for the given DRG for each approved day of stay beyond the upper day limit. Payment for long stay outliers shall be paid at 100 percent of the calculated amount and made at the time the claim is originally paid.

(2) Short stay outliers. Short stay outliers are incurred when a patient's length of stay is greater than two standard deviations from the geometric mean below the average statewide length of stay for a given DRG, rounded to the next highest whole number of days. Payment for short stay outliers will be 200 percent of the average daily rate for each day the patient qualifies up to the full DRG payment. Short stay outlier claims will be subject to QIO review and payment denied for inappropriate admissions.

(3) Cost outliers. Cases qualify as cost outliers when costs of service in a given case, not including any add-on amounts for direct or indirect medical education or disproportionate share costs exceed the cost threshold. This cost threshold is determined to be the greater of two times the statewide average DRG payment for that case or the hospital's individual DRG payment for that case plus \$16,000. Costs are calculated using hospital-specific cost-to-charge ratios determined in the base-year cost reports. Additional payment for cost outliers is 80 percent of the excess between the hospital's cost for the discharge and the cost threshold established to define cost outliers. Payment of cost outlier amounts shall be paid at 100 percent of the calculated amount and made at the time the claim is paid.

Those hospitals that are notified of any outlier review initiated by the QIO must submit all requested supporting data to the QIO within 60 days of the receipt of outlier review notification, or outlier payment will be forfeited and recouped. In addition, any hospital may request a review for outlier payment by submitting documentation to the QIO within 365 days of receipt of the outlier payment. If requests are not filed within 365 days, the provider loses the right to appeal or contest that payment.

(4) Day and cost outliers. Cases qualifying as both day and cost outliers are given additional payment as cost outliers only.

g. Billing for patient transfers and readmissions.

(1) Transfers between hospitals. When a Medicaid patient is transferred the initial hospital or unit is paid 100 percent of the average daily rate of the transferring hospital's payment for each day the patient remained in that hospital or unit, up to 100 percent of the entire DRG payment. The hospital or unit that received the transferred patient receives the entire DRG payment.

(2) Substance abuse units. When a patient is discharged to or from an acute care hospital and is admitted to or from a substance abuse unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

(3) Physical rehabilitation hospitals or units. When a patient requiring physical rehabilitation is discharged from an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring physical rehabilitation is discharged from a facility other than an acute care hospital and admitted to a rehabilitation hospital or unit certified pursuant to 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified physical rehabilitation hospital or unit and admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(4) Psychiatric units. When a patient is discharged to or from an acute care hospital before October 1, 2006, and is admitted to or from a psychiatric unit certified pursuant to paragraph 79.1(5) "r," both the discharging and admitting hospitals will receive 100 percent of the DRG payment.

Effective October 1, 2006, when a patient requiring psychiatric care is discharged from an acute care hospital and admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is through a per diem. The discharging hospital will receive 100 percent of the DRG payment. When a patient is discharged from a certified psychiatric unit and is admitted to an acute care hospital, the acute care hospital will receive 100 percent of the DRG payment.

When a patient requiring psychiatric care is discharged from a facility other than an acute care hospital on or after October 1, 2006, and is admitted to a psychiatric unit certified pursuant to paragraph 79.1(5) "r," and the admission is medically appropriate, then payment for time spent in the unit is based on a per diem. The other facility will receive payment in accordance with rules governing that facility. When a patient is discharged from a certified psychiatric unit on or after October 1, 2006, and is admitted to a facility other than an acute care hospital, the other facility will receive payment in accordance with rules governing that facility.

(5) Inpatient readmissions within seven days for same condition. When an inpatient is discharged or transferred from an acute care hospital and is readmitted as an inpatient to the same hospital within seven days for the same condition, any claim for the subsequent inpatient stay shall be combined with the claim for the original inpatient stay and payment shall be under a single DRG for both stays.

h. Covered DRGs. Medicaid DRGs cover services provided in acute care general hospitals, with the exception of services provided in physical rehabilitation hospitals and units certified pursuant to paragraph 79.1(5)“r,” and services provided on or after October 1, 2006, in psychiatric units certified pursuant to paragraph 79.1(5)“r,” which are paid per diem, as specified in paragraph 79.1(5)“i.”

i. Payment for certified physical rehabilitation hospitals and units and psychiatric units. Payment for services provided by a physical rehabilitation hospital or unit certified pursuant to paragraph 79.1(5)“r” and for services provided on or after October 1, 2006, in a psychiatric unit certified pursuant to paragraph 79.1(5)“r” is prospective. The payment is based on a per diem rate calculated for each hospital by establishing a base-year per diem rate to which an annual index is applied.

(1) Per diem calculation. The base rate shall be the medical assistance per diem rate as determined by the individual hospital’s base-year cost report pursuant to paragraph 79.1(5)“a.” No recognition will be given to the professional component of the hospital-based physicians except as noted under paragraph 79.1(5)“j.”

(2) Rescinded IAB 5/12/93, effective 7/1/93.

(3) Per diem reimbursement. Hospitals shall be reimbursed the lower of actual charges or the medical assistance cost per diem rate. The determination of the applicable rate shall be based on the hospital fiscal year aggregate of actual charges and medical assistance cost per diem rate. If an overpayment exists, the hospital will refund or have the overpayment deducted from subsequent billings.

(4) Per diem recalculation. Hospital prospective reimbursement rates shall be established as of October 1, 1987, for the remainder of the applicable hospital fiscal year. Beginning July 1, 1988, all updated rates shall be established based on the state’s fiscal year.

(5) Per diem billing. The current method for submitting billing and cost reports shall be maintained. All cost reports will be subject to desk review audit and, if necessary, a field audit.

j. Services covered by DRG payments. Medicaid adopts the Medicare definition of inpatient hospital services covered by the DRG prospective payment system except as indicated herein. As a result, combined billing for physician services is eliminated unless the hospital has approval from Medicare to combine bill the physician and hospital services. Teaching hospitals having Medicare’s approval to receive reasonable cost reimbursement for physician services under 42 CFR 415.58 as amended to November 25, 1991, are eligible for combined billing status if they have the Medicare approval notice on file with Iowa Medicaid as verification. Reasonable cost settlement will be made during the year-end settlement process. Services provided by certified nurse anesthetists (CRNAs) employed by a physician are covered by the physician reimbursement. Payment for the services of CRNAs employed by the hospital are included in the hospital’s reimbursement.

The cost for hospital-based ambulance transportation that results in an inpatient admission and hospital-based ambulance services performed while the recipient is an inpatient, in addition to all other inpatient services, is covered by the DRG payment. If, during the inpatient stay at the originating hospital, it becomes necessary to transport but not transfer the patient to another hospital or provider for treatment, with the patient remaining an inpatient at the originating hospital after that treatment, the originating hospital shall bear all costs incurred by that patient for the medical treatment or the ambulance transportation between the originating hospital and the other provider. The services furnished to the patient by the other provider shall be the responsibility of the originating hospital. Reimbursement to the originating hospital for all services is under the DRG payment. (See 441—subrule 78.11(4).)

k. Inflation factors, rebasing, and recalibration.

(1) Inflation factors shall be set annually at levels that ensure payments that are consistent with efficiency, economy, and quality of care and that are sufficient to enlist enough providers so that care and services are available at least to the extent that such care and services are available to the general population in the geographic area.

(2) Base amounts shall be rebased and weights recalibrated in 2005 and every three years thereafter. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the calendar year preceding the rebasing implementation year. If a hospital does not provide this cost report to the Iowa Medicaid enterprise provider cost audits and rate-setting unit by May 31 of a rebasing implementation year, the most recent submitted cost report will be used with the addition of a hospital market basket index inflation factor.

(3) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraphs 79.1(5)“y”(3), (6), and (9).

(4) Hospitals receiving reimbursement as critical access hospitals shall not receive inflation of base payment amounts and shall not have base amounts rebased or weights recalibrated pursuant to this paragraph.

l. Eligibility and payment. When a client is eligible for Medicaid for less than or equal to the average length of stay for that DRG, then payment equals 100 percent of the hospital’s average daily rate times the number of eligible hospital stay days up to the amount of the DRG payment. When a Medicaid client is eligible for greater than the average length of stay but less than the entire stay, then payment is treated as if the client were eligible for the entire length of stay.

Long stay outlier days are determined as the number of Medicaid eligible days beyond the outlier limits. The date of patient admission is the first date of service. Long stay outlier costs are accrued only during eligible days.

m. Payment to out-of-state hospitals. Payment made to out-of-state hospitals providing care to beneficiaries of Iowa’s Medicaid program is equal to either the Iowa statewide average blended base amount plus the statewide average capital cost add-on, multiplied by the DRG weight, or blended base and capital rates calculated by using 80 percent of the hospital’s submitted capital costs. Hospitals that submit a cost report no later than May 31 in the most recent rebasing year will receive a case-mix-adjusted blended base rate using hospital-specific, Iowa-only Medicaid data and the Iowa statewide average cost per discharge amount.

(1) Capital costs will be reimbursed at either the statewide average rate in place at the time of discharge, or the blended capital rate computed by using submitted cost report data.

(2) Hospitals that qualify for disproportionate share payment based on the definition established by their state’s Medicaid agency for the calculation of the Medicaid inpatient utilization rate will be eligible to receive disproportionate share payments according to paragraph “y.”

(3) If a hospital qualifies for reimbursement for direct medical education or indirect medical education under Medicare guidelines, it shall be reimbursed according to paragraph 79.1(5)“y.” 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 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 \$8,210,006. 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 \$14,415,396. 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 \$6,890,959. 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, is a voting member of the National Association of Children's Hospitals and Related Institutions, 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.

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 audits 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.

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. For the purpose of this provision, a “facility” place of service (POS) is defined as any of the following:

- (1) Hospital inpatient unit (POS 21).
- (2) Hospital outpatient unit (POS 22).
- (3) Hospital emergency room (POS 23).
- (4) Ambulatory surgical center (POS 24).
- (5) Skilled nursing facility (POS 31).
- (6) Inpatient psychiatric facility (POS 51).
- (7) Community mental health center (POS 53).
- (8) Comprehensive inpatient rehabilitation (POS 61).

79.1(8) Drugs. The amount of payment shall be based on several factors, subject to the upper limits in 42 CFR 447.500 to 447.520 as amended to October 7, 2008. The Medicaid program relies on information published by Medi-Span to classify drugs as brand-name or generic. Specialty drugs include biological drugs, blood-derived products, complex molecules, and select oral, injectable, and infused medications identified by the department and published on the specialty drug list.

a. Reimbursement for covered generic prescription drugs shall be the lowest of the following, as of the date of dispensing:

- (1) The estimated acquisition cost, defined:
 1. For covered nonspecialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g”; or
 2. For covered specialty generic prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph “g.”
- (2) The maximum allowable cost (MAC), defined as the upper limit for multiple source drugs established in accordance with the methodology of Centers for Medicare and Medicaid Services as described in 42 CFR 447.514, plus the professional dispensing fee specified in paragraph “g.”
- (3) The state maximum allowable cost (SMAC), defined as the average wholesale acquisition cost for a generic drug (the average price pharmacies pay to obtain the generic drug as evidenced by purchase records) adjusted by a multiplier of 1.2, plus the professional dispensing fee specified in paragraph “g.”
- (4) The submitted charge, representing the provider's usual and customary charge for the drug.

b. Reimbursement for covered brand-name prescription drugs shall be the lower of the following, as of the date of dispensing:

- (1) The estimated acquisition cost, defined:
 1. For covered nonspecialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 12 percent, plus the professional dispensing fee specified in paragraph “g”; or
 2. For covered specialty brand-name prescription drugs, as the average wholesale price as published by Medi-Span less 17 percent, plus the professional dispensing fee specified in paragraph “g.”
- (2) The submitted charge, representing the provider's usual and customary charge for the drug.

- c.* No payment shall be made for sales tax.
- d.* All hospitals that wish to administer vaccines which are available through the vaccines for children program to Medicaid members shall enroll in the vaccines for children program. In lieu of payment, vaccines available through the vaccines for children program shall be accessed from the department of public health for Medicaid members. Hospitals receive reimbursement for the administration of vaccines to Medicaid members through the DRG reimbursement for inpatients and APC reimbursement for outpatients.
- e.* The basis of payment for nonprescription drugs shall be the same as specified in paragraph “a” except that the department shall establish a maximum allowable reimbursable cost for these drugs using the average wholesale prices of the chemically equivalent products available. The department shall set the maximum allowable reimbursable cost at the median of those average wholesale prices. No exceptions for higher reimbursement will be approved.
- f.* An additional reimbursement amount of one cent per dose shall be added to the allowable ingredient cost of a prescription for an oral solid if the drug is dispensed to a patient in a nursing home in unit dose packaging prepared by the pharmacist.
- g.* For services rendered on or after August 1, 2011, the professional dispensing fee is \$6.20 or the pharmacy’s usual and customary fee, whichever is lower.
- h.* For purposes of this subrule, “equivalent products” shall be those that meet therapeutic equivalent standards as published in the federal Food and Drug Administration document, “Approved Prescription Drug Products With Therapeutic Equivalence Evaluations.”
- i.* Pharmacies and providers that are enrolled in the Iowa Medicaid program shall make available drug acquisition cost information, product availability information, and other information deemed necessary by the department to assist the department in monitoring and revising reimbursement rates subject to 79.1(8)“a”(3) and 79.1(8)“c” and for the efficient operation of the pharmacy benefit.
- (1) Pharmacies and providers shall produce and submit the requested information in the manner and format requested by the department or its designee at no cost to the department or its designee.
 - (2) Pharmacies and providers shall submit information to the department or its designee within 30 days following receipt of a request for information unless the department or its designee grants an extension upon written request of the pharmacy or provider.
- j.* Savings in Medicaid reimbursements attributable to the SMAC shall be used to pay costs associated with determination of the SMAC, before reversion to Medicaid.
- k.* Payment to physicians for physician-administered drugs billed with Healthcare Common Procedure Coding System (HCPCS) Level II “J” codes, as a physician service, shall be pursuant to physician payment policy under subrule 79.1(2).
- 79.1(9) HCBS consumer choices financial management.**
- a. Monthly allocation.* A financial management service provider shall receive a monthly fee as established in subrule 79.1(2) for each consumer electing to work with that provider under the HCBS consumer choices option. The financial management service provider shall also receive monthly the consumer’s individual budget amount as determined under 441—paragraph 78.34(13)“b,” 78.37(16)“b,” 78.38(9)“b,” 78.41(15)“b,” 78.43(15)“b,” or 78.46(6)“b.”
- b. Cost settlement.* The financial management service shall pay from the monthly allocated individual budget amount for independent support broker service, self-directed personal care services, individual-directed goods and services, and self-directed community supports and employment as authorized by the consumer. On a quarterly basis during the federal fiscal year, the department shall perform a cost settlement. The cost settlement represents the difference between the amount received for the allocated individual budget and the amount actually utilized.
- c. Start-up grants.* A qualifying financial management service provider may be reimbursed up to \$10,000 for the costs associated for starting the service.
- (1) Start-up reimbursement shall be issued as long as funds for this purpose are available from the Robert Wood Johnson Foundation or until September 30, 2007.
 - (2) Funds will not be distributed until the provider meets all of the following criteria:

1. The provider shall meet the requirements to be certified to participate in an HCBS waiver program as set forth in 441—subrule 77.30(13), 77.33(16), 77.34(9), 77.37(28), 77.39(26), or 77.41(7), including successful completion of a readiness review as approved by the department.

2. The provider shall enter into an agreement with the department to provide statewide coverage for not less than one year from the date that the funds are distributed.

3. The provider shall submit to the department for approval a budget identifying the costs associated with starting financial management service.

(3) If the provider fails to continue to meet these qualifications after the funds have been distributed, the department may recoup all or part of the funds paid to the provider.

79.1(10) Prohibition against reassignment of claims. No payment under the medical assistance program for any care or service provided to a patient by any health care provider shall be made to anyone other than the providers. However with respect to physicians, dentists or other individual practitioners direct payment may be made to the employer of the practitioner if the practitioner is required as a condition of employment to turn over fees to the employer; or where the care or service was provided in a facility, to the facility in which the care or service was provided if there is a contractual arrangement between the practitioner and the facility whereby the facility submits the claim for reimbursement; or to a foundation, plan or similar organization including a health maintenance organization which furnishes health care through an organized health care delivery system if there is a contractual agreement between organization and the person furnishing the service under which the organization bills or receives payment for the person's services. Payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order. Payment may be made to a business agent, such as a billing service or accounting firm, which renders statements and receives payment in the name of the provider when the agent's compensation for this service is (1) reasonably related to the cost or processing the billing; (2) not related on a percentage or other basis to the dollar amounts to be billed or collected; and (3) not dependent upon the actual collection of payment. Nothing in this rule shall preclude making payment to the estate of a deceased practitioner.

79.1(11) Prohibition against factoring. Payment under the medical assistance program for any care or service furnished to an individual by providers as specified in 79.1(1) shall not be made to or through a factor either directly or by virtue of power of attorney given by the provider to the factor. A factor is defined as an organization, collection agency, or service bureau which, or an individual who, advances money to a provider for accounts receivable which have been assigned or sold or otherwise transferred including transfer through the use of power of attorney to the organization or individual for an added fee or reduction of a portion of the accounts receivable. The term factor does not include business representatives such as billing agents or accounting firms which render statements and receive payments in the name of the individual provider provided that the compensation of the business representative for the service is reasonably related to the cost of processing the billings and is not related on a percentage or other basis to the dollar amounts to be billed or collected.

79.1(12) Reasonable charges for services, supplies, and equipment. For selected medical services, supplies, and equipment, including equipment servicing, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments shall be the lowest charges for which the devices are widely and consistently available in a locality. For those selected services and items furnished under part B of Medicare and Medicaid, the upper limits shall be the lowest charge levels recognized under Medicare. For those selected services and items furnished only under Medicaid, the upper limits shall be the lowest charge levels determined by the department according to the Medicare reimbursement method.

a. For any noninstitutional item or service furnished under both Medicare and Medicaid, the department shall pay no more than the reasonable charge established for that item or service by the part B Medicare carrier serving part or all of Iowa. Noninstitutional services do not include practitioner's services, such as physicians, pharmacies, or out-patient hospital services.

b. For all other noninstitutional items or services furnished only under Medicaid, the department shall pay no more than the customary charge for a provider or the prevailing charges in the locality for comparable items or services under comparable circumstances, whichever is lower.

79.1(13) Copayment by member. A copayment in the amount specified shall be charged to members for the following covered services:

a. The member shall pay a copayment for each covered prescription or refill of any covered drug as follows:

(1) One dollar for generic drugs and preferred brand-name drugs. Any brand-name drug that is not subject to prior approval based on nonpreferred status on the preferred drug list published by the department pursuant to Iowa Code section 249A.20A shall be treated as a preferred brand-name drug.

(2) Rescinded IAB 7/6/05, effective 7/1/05.

(3) One dollar for nonpreferred brand-name drugs for which the cost to the state is less than \$25.

(4) Two dollars for nonpreferred brand-name drugs for which the cost to the state is \$25.01 to \$50.

(5) Three dollars for nonpreferred brand-name drugs for which the cost to the state is \$50.01 or more.

(6) For the purpose of this paragraph, the cost to the state is determined without regard to federal financial participation in the Medicaid program or to any rebates received.

b. The member shall pay \$1 copayment for total covered service rendered on a given date for podiatrists' services, chiropractors' services, and services of independently practicing physical therapists.

c. The member shall pay \$2 copayment for total covered services rendered on a given date for medical equipment and appliances, prosthetic devices and medical supplies as defined in 441—78.10(249A), orthopedic shoes, services of audiologists, services of hearing aid dealers except the hearing aid, services of optometrists, opticians, rehabilitation agencies, and psychologists, and ambulance services.

d. The member shall pay \$3 copayment for:

(1) Total covered service rendered on a given date for dental services and hearing aids.

(2) All covered services rendered in a physician office visit on a given date. For the purposes of this subparagraph, "physician" means either a doctor of allopathic medicine (M.D.) or a doctor of osteopathic medicine (D.O.), as defined under rule 441—77.1(249A).

e. Copayment charges are not applicable to persons under age 21.

f. Copayment charges are not applicable to family planning services or supplies.

g. Copayment charges are not applicable for a member receiving inpatient care in a hospital, nursing facility, state mental health institution, or other medical institution if the person is required, as a condition of receiving services in the institution, to spend for costs of necessary medical care all but a minimal amount of income for personal needs.

h. The member shall pay \$1 for each federal Medicare Part B crossover claim submitted to the Medicaid program when the services provided have a Medicaid copayment as set forth above.

i. Copayment charges are not applicable to services furnished pregnant women.

j. All providers are prohibited from offering or providing copayment related discounts, rebates, or similar incentives for the purpose of soliciting the patronage of Medicaid members.

k. Copayment charges are not applicable for emergency services. Emergency services are defined as services provided in a hospital, clinic, office, or other facility that is equipped to furnish the required care, after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), that the absence of immediate medical attention could reasonably be expected to result in:

(1) Placing the patient's health in serious jeopardy,

(2) Serious impairment to bodily functions, or

(3) Serious dysfunction of any bodily organ or part.

l. Copayment charges are not applicable for services rendered by a health maintenance organization in which the member is enrolled.

m. No provider of service participating in the Medicaid program may deny care or services to a person eligible for care or services under the program because of the person's inability to pay a copayment. However, this rule does not change the fact that a member is liable for the charges and it does not preclude the provider from attempting to collect them.

n. The member shall pay a \$3 copayment for each visit to a hospital emergency room for treatment that does not meet the criteria for an emergency service as defined in paragraph 79.1(13) "k." This \$3 copayment shall not apply if the visit to the emergency room results in a hospital admission.

79.1(14) Reimbursement for hospice services.

a. Medicaid hospice rates. The Medicaid hospice rates are based on the methodology used in setting Medicare rates, adjusted to disregard cost offsets attributable to Medicare coinsurance amounts, and with application of the appropriate area wage adjustments for the categories of care provided.

Hospices are reimbursed at one of four predetermined rates based on the level of care furnished to the individual for that day. Payments to a hospice for inpatient care are subject to the limitations imposed by Medicare. The levels of care into which each day of care is classified are as follows:

- (1) Routine home care.
- (2) Continuous home care.
- (3) Inpatient respite care.
- (4) General inpatient care.

b. Adjustment to hospice rates. An adjustment to hospice reimbursement is made when a recipient residing in a nursing facility elects the hospice benefit. The adjustment will be a room and board rate that is equal to the rate at which the facility is paid for reserved bed days or 95 percent of the facility's Medicaid reimbursement rate, whichever is greater. Room and board services include the performance of personal care services, including assistance in activities of daily living, socializing activities, administration of medication, maintaining the cleanliness of a resident's room and supervising and assisting in the use of durable medical equipment and prescribed therapies.

For hospice recipients entering a nursing facility the adjustment will be effective the date of entry. For persons in nursing facilities prior to hospice election, the adjustment rate shall be effective the date of election.

For individuals who have client participation amounts attributable to their cost of care, the adjustment to the hospice will be reduced by the amount of client participation as determined by the department. The hospice will be responsible for collecting the client participation amount due the hospice unless the hospice and the nursing facility jointly determine the nursing facility is to collect the client participation.

c. Payment for day of discharge. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the recipient dies as an inpatient. When the recipient is discharged as deceased, the inpatient rate (general or respite) is to be paid for the discharge date.

d. Hospice cap. Overall aggregate payments made to a hospice during a hospice cap period are limited or capped. The hospice cap year begins November 1 and ends October 31 of the next year. The cap amount for each hospice is calculated by multiplying the number of beneficiaries electing hospice care from that hospice during the cap period by the base statutory amount, adjusted to reflect the percentage increase or decrease in the medical care expenditure category of the Consumer Price Index for all urban consumers published by the Bureau of Labor Statistics. Payments made to a hospice but not included in the cap include room and board payment to a nursing home. Any payment in excess of the cap must be refunded to the department by the hospice.

e. Limitation of payments for inpatient care. Payments to a hospice for inpatient care shall be limited according to the number of days of inpatient care furnished to Medicaid patients. During the 12-month period beginning November 1 of each year and ending October 31, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) shall not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. Medicaid recipients afflicted with acquired immunodeficiency syndrome (AIDS) are excluded in calculating this inpatient care limitation. This limitation is applied once each year, at the end of the hospices' "cap period" (November 1 to October 31). For purposes of this computation, if it is determined

that the inpatient rate should not be paid, any days for which the hospice receives payment at a home care rate will not be counted as inpatient days. The limitation is calculated as follows:

(1) The maximum allowable number of inpatient days will be calculated by multiplying the total number of days of Medicaid hospice care by 0.2.

(2) If the total number of days of inpatient care furnished to Medicaid hospice patients is less than or equal to the maximum, no adjustment will be necessary.

(3) If the total number of days of inpatient care exceeded the maximum allowable number, the limitation will be determined by:

1. Calculating a ratio of the maximum allowable days to the number of actual days of inpatient care, and multiplying this ratio by the total reimbursement for inpatient care (general inpatient and inpatient respite reimbursement) that was made.

2. Multiplying excess inpatient care days by the routine home care rate.

3. Adding together the amounts calculated in "1" and "2."

4. Comparing the amount in "3" with interim payments made to the hospice for inpatient care during the "cap period."

Any excess reimbursement shall be refunded by the hospice.

f. Location of services. Claims must identify the geographic location where the service is provided (as distinct from the location of the hospice).

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

a. *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.

c. Prospective rates for new providers other than respite.

(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 other than respite.

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

f. Retrospective adjustments.

(1) Retrospective adjustments shall be made based on reconciliation of provider's reasonable and proper actual service costs with the revenues received for those services as reported on Form 470-3449, Supplemental Schedule, accompanying Form SS-1703-0, Financial and Statistical Report for Purchase of Service.

(2) Revenues exceeding adjusted actual costs by more than 2.5 percent shall be remitted to the department. Payment will be due upon notice of the new rates and retrospective rate adjustment.

(3) Providers who do not reimburse revenues exceeding 102.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 102.5 percent of the actual costs deducted from future payments.

g. Supported community living daily rate. For purposes of determining the daily rate for supported community living services, providers are treated as new providers until they have submitted an annual report including at least six months of actual costs for the same consumers at the same site with no significant change in any consumer's needs, or if there is a subsequent change in the consumers at a site or in any consumer's needs. Individual prospective daily rates are determined for each consumer. These rates may be adjusted no more than once every three months if there is a vacancy at the site for over 30 days or the consumer's needs have significantly changed. Rates adjusted on this basis will become effective the month a new cost report is submitted. Retrospective adjustments of the prospective daily rates are based on each site's average costs.

79.1(16) Outpatient reimbursement for hospitals.

a. Definitions.

"Allowable costs" means the costs defined as allowable in 42 CFR, Chapter IV, Part 413, as amended to October 1, 2007, except for the purposes of calculating direct medical education costs, where only the reported costs of the interns and residents are allowed. Further, costs are allowable only to the extent that they relate to patient care; are reasonable, ordinary, and necessary; and are not in excess of what a prudent and cost-conscious buyer would pay for the given service or item.

"Ambulatory payment classification" or *"APC"* means an outpatient service or group of services for which a single rate is set. The services or groups of services are determined according to the typical clinical characteristics, the resource use, and the costs associated with the service or services.

"Ambulatory payment classification relative weight" or *"APC relative weight"* means the relative value assigned to each APC.

"Ancillary service" means a supplemental service that supports the diagnosis or treatment of the patient's condition. Examples include diagnostic testing or screening services and rehabilitative services such as physical or occupational therapy.

"APC service" means a service that is priced and paid using the APC system.

"Base year cost report," for rates effective January 1, 2009, means the hospital's cost report with fiscal year end on or after January 1, 2007, and before January 1, 2008. Cost reports shall be reviewed using Medicare's cost reporting and cost reimbursement principles for those cost reporting periods.

"Blended base APC rate" shall mean the hospital-specific base APC rate, plus the statewide base APC rate, divided by two. The costs of hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report shall not be used in determining the statewide base APC rate.

"Case-mix index" shall mean an arithmetical index measuring the relative average costliness of outpatient cases treated in a hospital, compared to the statewide average.

"Cost outlier" shall mean services provided during a single visit that have an extraordinarily high cost as established in paragraph "g" and are therefore eligible for additional payments above and beyond the base APC payment.

"Current procedural terminology—fourth edition (CPT-4)" is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. The CPT-4 coding is maintained by the American Medical Association and is updated yearly.

"Diagnostic service" means an examination or procedure performed to obtain information regarding the medical condition of an outpatient.

"Direct medical education costs" shall mean costs directly associated with the medical education of interns and residents or other medical education programs, such as a nursing education program or allied health programs, conducted in an outpatient setting, that qualify for payment as medical education costs under the Medicare program. The amount of direct medical education costs is determined from the hospital base-year cost reports and is inflated in determining the direct medical education rate.

"Direct medical education rate" shall mean a rate calculated for a hospital reporting medical education costs on the Medicare cost report (CMS 2552). The rate is calculated using the following formula: Direct medical education costs are multiplied by the percentage of valid claims to total claims, further multiplied by inflation factors, then divided by outpatient visits.

“Discount factor” means the percentage discount applied to additional APCs when more than one APC is provided during the same visit (including the same APC provided more than once). Not all APCs are subject to a discount factor.

“GME/DSH fund apportionment claim set” means the hospital’s applicable Medicaid claims paid from July 1, 2008, through June 30, 2009. The claim set is updated every three years in July.

“GME/DSH fund implementation year” means 2009.

“Graduate medical education and disproportionate share fund” or *“GME/DSH fund”* means a reimbursement fund developed as an adjunct reimbursement methodology to directly reimburse qualifying hospitals for the direct costs of interns and residents associated with the operation of graduate medical education programs for outpatient services.

“Healthcare common procedures coding system” or *“HCPCS”* means the national uniform coding method that is maintained by the Centers for Medicare and Medicaid Services (CMS) and that incorporates the American Medical Association publication Physicians Current Procedural Terminology (CPT) and the three HCPCS unique coding levels I, II, and III.

“Hospital-based clinic” means a clinic that is owned by the hospital, operated by the hospital under its hospital license, and on the premises of the hospital.

“International classifications of diseases—fourth edition, ninth revision (ICD-9)” is a systematic method used to classify and provide standardization to coding practices which are used to describe the diagnosis, symptom, complaint, condition or cause of a person’s injury or illness.

“Medicaid claim set” means the hospital’s applicable Medicaid claims for the period of January 1, 2006, through December 31, 2007, and paid through March 31, 2008.

“Modifier” means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

“Multiple significant procedure discounting” means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

“Observation services” means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

“Outpatient hospital services” means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

“Outpatient prospective payment system” or *“OPPS”* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare’s outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

“Outpatient visit” shall mean those hospital-based outpatient services which are billed on a single claim form.

“Packaged service” means a service that is secondary to other services but is considered an integral part of another service.

“Pass-through” means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

“Quality improvement organization” or *“QIO”* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments

for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

“*Rebasing*” shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

“*Significant procedure*” shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

“*Status indicator*” or “*SI*” means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPSS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

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

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital’s financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member’s condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital’s DRG reimbursement rate for the inpatient services.

(3) All psychiatric services for members who have a primary diagnosis of mental illness and are enrolled in the Iowa Plan program under 441—Chapter 88 shall be the responsibility of the Iowa Plan contractor and shall not be otherwise payable by Iowa Medicaid. The only exceptions to this policy are reference laboratory and radiology services, which will be payable by fee schedule or APC.

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

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

c. Payment for outpatient hospital services.

(1) Outpatient hospital services shall be reimbursed according to the first of the following methodologies that applies to the service:

1. Any specific rate or methodology established by rule for the particular service.
2. The OPSS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)“c.”

(2) Except as provided in paragraph 79.1(16)“h,” outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. The department adopts and incorporates by reference the OPSS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights and APCs shall be updated pursuant to paragraph 79.1(16)“j.”

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)“e.”

2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.

3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPSS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPSS APC or under another payment system and whether particular OPSS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPSS APC and services that are not paid under an OPSS APC.

Indicator	Item, Code, or Service	OPSS Payment Status
A	<p>Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPSS, such as:</p> <ul style="list-style-type: none"> ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients. ● Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital. 	<p>For services covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>For services not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>
B	Codes that are not paid by Medicare on an outpatient hospital basis	<p>Not paid under OPSS APC.</p> <ul style="list-style-type: none"> ● May be paid when submitted on a different bill type other than outpatient hospital (13x). ● An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	<p>If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPSS APC. Admit the patient and bill as inpatient care.</p>
D	Discontinued codes	Not paid under OPSS APC or any other Medicaid payment system.
E	<p>Items, codes, and services:</p> <ul style="list-style-type: none"> ● That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or ● That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or ● For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid. 	<p>If covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1) "c."</p> <p>If not covered by Iowa Medicaid, the item, code, or service is not paid under OPSS APC or any other Medicaid payment system.</p>

F	<p>Certified registered nurse anesthetist services</p> <p>Corneal tissue acquisition</p> <p>Hepatitis B vaccines</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>
G	<p>Pass-through drugs and biologicals</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
H	<p>Pass-through device categories</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.</p>
K	<p>Non-pass-through drugs and biologicals</p> <p>Therapeutic radiopharmaceuticals</p>	<p>If covered by Iowa Medicaid, the item is:</p> <ul style="list-style-type: none"> • Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. • Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c” when either no APC or APC weight is established. <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
L	<p>Influenza vaccine</p> <p>Pneumococcal pneumonia vaccine</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.</p>
M	<p>Items and services not billable to the Medicare fiscal intermediary</p>	<p>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.”</p> <p>If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.</p>

N	Packaged services not subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC. Payment, including outliers, is included with payment for other services; therefore, no separate payment is made.
P	Partial hospitalization	Not a covered service under Iowa Medicaid.
Q1	STVX-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “S,” “T,” “V,” or “X.” • In all other circumstances, payment is made through a separate APC payment.
Q2	T-packaged codes	<p>Paid under OPPS APC.</p> <ul style="list-style-type: none"> • Packaged APC payment if billed on the same date of service as HCPCS code assigned status indicator “T.” • In all other circumstances, payment is made through a separate APC payment.
Q3	Codes that may be paid through a composite APC	<p>If covered by Iowa Medicaid, the code is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the code is not paid under OPPS APC or any other Medicaid payment system.</p>
R	Blood and blood products	<p>If covered by Iowa Medicaid, the item is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.</p>
S	Significant procedure, not discounted when multiple	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
T	Significant procedure, multiple reduction applies	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>
U	Brachytherapy sources	<p>If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.</p>

V	Clinic or emergency department visit	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room pursuant to 79.1(16)“r.”</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
X	Ancillary services	<p>If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment.</p> <p>If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.</p>
Y	Nonimplantable durable medical equipment	<p>For items covered by Iowa Medicaid as an outpatient hospital service, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)“c.”</p> <p>For items not covered by Iowa Medicaid as an outpatient hospital service, the item is not paid as an outpatient hospital service, but may be paid by Iowa Medicaid under the specific rate or methodology established by other rules (other than outpatient hospital).</p>

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using the Medicaid claim set.

(1) Hospital-specific case-mix indices are calculated by summing the relative weights for each APC service at that hospital and dividing the total by the number of APC services for that hospital.

(2) The statewide case-mix index is calculated by summing the relative weights for each APC service for all claims and dividing the total by the statewide total number of APC services. Claims for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report are not used in calculating the statewide case-mix index.

e. Calculation of the hospital-specific base APC rates.

(1) Using the hospital’s base-year cost report, hospital-specific outpatient cost-to-charge ratios are calculated for each ancillary and outpatient cost center of the Medicare cost report, Form CMS 2552-96.

(2) The cost-to-charge ratios are applied to each line item charge reported on claims from the Medicaid claim set to calculate the Medicaid cost per service. The hospital’s total outpatient Medicaid cost is the sum of the Medicaid cost per service for all line items.

(3) The following items are subtracted from the hospital’s total outpatient Medicaid costs:

1. The total calculated Medicaid direct medical education cost for interns and residents based on the hospital’s base-year cost report.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n.”

3. The total calculated Medicaid cost for ambulance services.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule.

(4) The remaining amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the hospital-specific case-mix index, and then divided by the total number of APC services for that hospital from the Medicaid claim set.

(5) Hospital-specific base APC rates are not computed for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report.

f. Calculation of statewide base APC rate.

(1) The statewide average base APC rate is calculated by summing the outpatient Medicaid cost for all hospitals and subtracting the following:

1. The total calculated Medicaid direct medical education cost for interns and residents for all hospitals.

2. The total calculated Medicaid cost for services listed at 441—subrule 78.31(1), paragraphs “g” to “n,” for all hospitals.

3. The total calculated Medicaid cost for ambulance services for all hospitals.

4. The total calculated Medicaid cost for services paid based on the Iowa Medicaid fee schedule for all hospitals.

(2) The resulting amount is multiplied by a factor to limit aggregate expenditures to available funding, divided by the statewide case-mix index, and then divided by the statewide total number of APC services from the Medicaid claim set.

(3) Data for hospitals receiving reimbursement as critical access hospitals during any of the period included in the base-year cost report is not used in calculating the statewide average base APC rate.

g. Cost outlier payment policy. Additional payment is made for services provided during a single visit that exceed the following Medicaid criteria of cost outliers for each APC. Outlier payments are determined on an APC-by-APC basis.

(1) An APC qualifies as a cost outlier when the cost of the service exceeds both the multiple threshold and the fixed-dollar threshold.

(2) The multiple threshold is met when the cost of furnishing an APC service exceeds 1.75 times the APC payment amount.

(3) The fixed-dollar threshold is met when the cost of furnishing an APC service exceeds the APC payment amount plus \$2,000.

(4) If both the multiple threshold and the fixed-dollar threshold are met, the outlier payment is calculated as 50 percent of the amount by which the hospital’s cost of furnishing the APC service or procedure exceeds the multiple threshold.

(5) The cost of furnishing the APC service or procedure is calculated using a single overall hospital-specific cost-to-charge ratio determined from the base-year cost report. Costs appearing on a claim that are attributable to packaged APC services for which no separate payment is made are allocated to all nonpackaged APC services that appear on that claim. The amount allocated to each nonpackaged APC service is based on the proportion the APC payment rate for that APC service bears to the total APC rates for all nonpackaged APC services on the claim.

h. Payment to critical access hospitals. Initial, interim payments to critical access hospitals as defined in paragraph 79.1(5)“a” shall be the hospital’s line-item charge multiplied by the hospital’s Medicaid outpatient cost-to-charge ratio. These interim payments are subject to annual retrospective adjustment equal to the difference between the reasonable costs of covered services provided to eligible fee-for-service Medicaid members (excluding members in managed care) and the Medicaid reimbursement received. The department shall determine the reasonable costs of services based on the hospital’s annual cost reports and Medicare cost principles. When the interim amounts paid exceed reasonable costs, the department shall recover the difference.

(1) After any retrospective adjustment, the department shall update the cost-to-charge ratio to reflect as accurately as is possible the reasonable costs of providing the covered service to eligible fee-for-service Medicaid members for the coming year. The department shall base these changes on the most recent utilization as submitted to the Iowa Medicaid enterprise provider cost audit and rate-setting unit and Medicare cost principles.

(2) Once a hospital begins receiving reimbursement as a critical access hospital, the cost-to-charge ratio is not subject to rebasing as provided in paragraph 79.1(16)“j.”

i. Cost-reporting requirements. Hospitals shall prepare annual cost reports in accordance with generally accepted accounting principles as defined by the American Institute of Certified Public Accountants and in accordance with Medicare Provider Reimbursement Manual, CMS Publication 15, subject to the exceptions and limitations provided in this rule.

(1) Using electronic media, each hospital shall submit the following:

1. The hospital's Medicare cost report (Form CMS 2552-96, Hospitals and Healthcare Complex Cost Report);

2. Either Form 470-4515, Critical Access Hospital Supplemental Cost Report, or Form 470-4514, Hospital Supplemental Cost Report; and

3. A copy of the revenue code crosswalk used to prepare the Medicare cost report.

- (2) The cost reports and supporting documentation shall be sent to the Iowa Medicaid Enterprise, Provider Cost Audit and Rate Setting Unit, 100 Army Post Road, P.O. Box 36450, Des Moines, Iowa 50315.

- (3) The cost reports shall be submitted on or before the last day of the fifth calendar month following the close of the period covered by the report. For fiscal periods ending on a day other than the last day of the month, cost reports are due 150 days after the last day of the cost-reporting period. Extensions of the due date for filing a cost report granted by the Medicare fiscal intermediary shall be accepted by Iowa Medicaid.

j. Rebasing.

- (1) Effective January 1, 2009, and annually thereafter, the department shall update the OPPS APC relative weights using the most current calendar update as published by the Centers for Medicare and Medicaid Services.

- (2) Effective January 1, 2009, and every three years thereafter, blended base APC rates shall be rebased. Cost reports used in rebasing shall be the hospital fiscal year-end Form CMS 2552-96, Hospital and Healthcare Complex Cost Report, as submitted to Medicare in accordance with Medicare cost report submission time lines for the hospital fiscal year ending during the preceding calendar year. If a hospital does not provide this cost report, including the Medicaid cost report and revenue code crosswalk, to the Iowa Medicaid enterprise provider cost audit and rate-setting unit by May 31 of a year in which rebasing occurs, the most recent submitted cost report will be used.

- (3) Effective January 1, 2009, and every three years thereafter, case-mix indices shall be recalculated using valid claims most nearly matching each hospital's fiscal year end.

- (4) The graduate medical education and disproportionate share fund shall be updated as provided in subparagraph 79.1(16) "v"(3).

k. Payment to out-of-state hospitals. Out-of-state hospitals providing care to members of Iowa's Medicaid program shall be reimbursed in the same manner as Iowa hospitals, except as provided in subparagraphs (1) and (2).

- (1) For out-of-state hospitals that submit a cost report no later than May 31 in the most recent rebasing year, APC payment amounts will be based on the blended base APC rate using hospital-specific, Iowa-only Medicaid data. For other out-of-state hospitals, APC payment amounts will be based on the Iowa statewide base APC rate.

- (2) Out-of-state hospitals do not qualify for direct medical education payments pursuant to paragraph 79.1(16) "v."

l. Preadmission, preauthorization or inappropriate services. Inpatient or outpatient services that require preadmission or preprocedure approval by the quality improvement organization (QIO) are updated yearly and are available from the QIO.

- (1) The hospital shall provide the QIO authorization number on the claim form to receive payment. Claims for services requiring preadmission or preprocedure approval that are submitted without this authorization number will be denied.

- (2) To safeguard against other inappropriate practices, the department, through the QIO, will monitor admission practices and quality of care. If an abuse of the prospective payment system is identified, payments for abusive practices may be reduced or denied. In reducing or denying payment, Medicaid adopts the Medicare QIO regulations.

m. Health care access assessment inflation factor. Effective with the implementation of the health care access assessment paid pursuant to 441—Chapter 36, Division III, a health care access assessment inflation factor shall be applied to the Medicaid blended base APC rate as otherwise calculated pursuant to this subrule for all "participating hospitals" as defined in 441—subrule 36.10(1).

(1) Calculation of inflation factor. The health care access assessment inflation factor for participating hospitals shall be calculated by dividing the amount allowed under the Medicare outpatient upper payment limit for the fiscal year beginning July 1, 2010, by the sum of the projected expenditures for participating hospitals for the fiscal year beginning July 1, 2010, as determined by the fiscal management division of the department, and the amount allowed under the Medicare outpatient upper payment limit.

(2) Implementation date. The health care access assessment inflation factor shall not be implemented until federal financial participation to match money collected from the health care access assessment pursuant to 441—Chapter 36, Division III, has been approved by the federal Centers for Medicare and Medicaid Services.

(3) End date. Application of the health care access assessment inflation factor shall terminate if the health care access assessment is terminated pursuant to rule 441—36.12(83GA,SF2388). If federal match money is unavailable for a retroactive period or the authority to collect the assessment is rescinded for a retroactive period, the department shall:

1. Recalculate Medicaid rates in effect during that period without the application of the health care access assessment inflation factor;
2. Recompute Medicaid payments due based on the recalculated Medicaid rates;
3. Recoup any previous overpayments; and
4. Determine for each hospital the amount of health care access assessment collected during that period and refund that amount to the facility.

n. Determination of inpatient admission. A person is considered to be an inpatient when a formal inpatient admission occurs, when a physician intends to admit a person as an inpatient, or when a physician determines that a person being observed as an outpatient in an observation or holding bed should be admitted to the hospital as an inpatient. In cases involving outpatient observation status, the determinant of patient status is not the length of time the patient was being observed, rather whether the observation period was medically necessary to determine whether a patient should be admitted to the hospital as an inpatient. Outpatient observation lasting greater than a 24-hour period will be subject to review by the QIO to determine the medical necessity of each case. For those outpatient observation cases where medical necessity is not established, reimbursement shall be denied for the services found to be unnecessary for the provision of that care, such as the use of the observation room.

o. Inpatient admission after outpatient services. If a patient is admitted as an inpatient within three days of the day in which outpatient services were rendered, all outpatient services related to the principal diagnosis are considered inpatient services for billing purposes. The day of formal admission as an inpatient is considered as the first day of hospital inpatient services. EXCEPTION: This requirement does not apply to critical access hospitals.

p. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

q. Determination of payment amounts for mental health noninpatient (NIP) services. Mental health NIP services are limited as set forth at 441—subparagraph 78.31(4)“d”(7) and are reimbursed on a fee schedule basis. Mental health NIP services are the responsibility of the managed mental health care and substance abuse (Iowa Plan) contractor for persons eligible for managed mental health care.

r. Services delivered in the emergency room. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows:

(1) If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

(2) If the emergency room visit does not result in an inpatient hospital admission but involves emergency services as defined in paragraph 79.1(13)“k,” payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

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

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

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

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

s. Limit on payments. Payments under the ambulatory payment classification (APC) methodology, as well as other payments for outpatient services, are subject to upper limit rules set forth in 42 CFR 447.321 as amended to September 5, 2001, and 447.325 as amended to January 26, 1993. Requirements under these sections state that, in general, Medicaid may not make payments to providers that would exceed the amount that would be payable to providers under comparable circumstances under Medicare.

t. Government-owned facilities. Rescinded IAB 6/30/10, effective 7/1/10.

u. QIO review. The QIO will review a yearly random sample of hospital outpatient service cases performed for Medicaid members and identified on claims data from all Iowa and bordering state hospitals in accordance with the terms in the contract between the department and the QIO. The QIO contract is available for review at the Iowa Medicaid Enterprise Office, 100 Army Post Road, Des Moines, Iowa 50315.

v. Graduate medical education and disproportionate share fund. Payment shall be made to hospitals qualifying for direct medical education directly from the graduate medical education and disproportionate share fund. The requirements to receive payments from the fund, the amount allocated to the fund and the methodology used to determine the distribution amounts from the fund are as follows:

(1) Qualifying for direct medical education. Iowa hospitals qualify for direct medical education payments if direct medical education costs that qualify for payment as medical education costs under the Medicare program are contained in the hospital's base year cost report and in the most recent cost report submitted before the start of the state fiscal year for which payments are being made. Out-of-state hospitals do not qualify for direct medical education payments.

(2) Allocation to fund for direct medical education. The total annual state fiscal year funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to outpatient services is \$2,776,336. If a hospital fails to qualify for direct medical education payments from the fund because the hospital does not report direct medical education costs that qualify for payment as medical education costs under the Medicare program in the most recent cost report submitted before the start of the state fiscal year for which payments are being made, the amount of money that would have been paid to that hospital shall be removed from the fund.

(3) Distribution to qualifying hospitals for direct medical education. Distribution of the amount in the fund for direct medical education shall be on a monthly basis. To determine the amount to be distributed to each qualifying hospital for direct medical education, the following formula is used:

1. Multiply the total count of outpatient visits for claims paid from the GME/DSH fund apportionment claim set for each hospital reporting direct medical education costs that qualify for payment as medical education costs under the Medicare program in the hospital's base year cost report by each hospital's direct medical education rate to obtain a dollar value.

2. Sum the dollar values for each hospital, then divide each hospital's dollar value by the total dollar value, resulting in a percentage.

3. Multiply each hospital's percentage by the amount allocated for direct medical education to determine the payment to each hospital.

w. Final settlement for state-owned teaching hospital.

(1) Effective July 1, 2010, total annual payments to an Iowa state-owned hospital for inpatient and outpatient hospital services shall equal 100 percent of allowable medical assistance program costs, not to exceed the sum of the following:

1. Payments for inpatient hospital services calculated in accordance with subrule 79.1(5), plus
2. Payment for outpatient hospital services calculated in accordance with subrule 79.1(16), plus
3. \$9,900,000.

(2) One-twelfth of the \$9,900,000 increase in reimbursement shall be distributed to the hospital on a monthly basis.

(3) The Iowa Medicaid enterprise shall complete a final settlement based on the hospital's Medicare cost report. If the aggregate payments are less than the hospital's actual medical assistance program costs, no additional payment shall be made.

(4) If the sum of the inpatient hospital service payments plus outpatient hospital service payments plus the \$9,900,000 exceeds 100 percent of allowable inpatient and outpatient costs, the department shall request and collect from the hospital the amount by which payments exceed actual medical assistance program costs.

79.1(17) Reimbursement for home- and community-based services home and vehicle modification and equipment. Payment is made for home and vehicle modifications, assistive devices, specialized medical equipment, and environmental modifications and adaptive devices at the amount authorized by the department through a quotation, contract, or invoice submitted by the provider.

a. The case manager shall submit the service plan and the contract, invoice or quotations from the providers to the Iowa Medicaid enterprise for prior approval before the modification is initiated or the equipment is purchased. Payment shall not be approved for duplicate items.

b. Whenever possible, three itemized bids for the modification or quotations for equipment purchase shall be presented for review. The amount payable shall be based on the least expensive item that meets the member's medical needs.

c. Payment for most items shall be based on a fee schedule and shall conform to the limitations set forth in subrule 79.1(12).

(1) For services and items that are furnished under Part B of Medicare, the fee shall be the lowest charge allowed under Medicare.

(2) For services and items that are furnished only under Medicaid, the fee shall be the lowest charge determined by the department according to the Medicare reimbursement method described in Section 1834(a) of the Social Security Act (42 U.S.C. 1395m), Payment for Durable Medical Equipment.

(3) Payment for supplies with no established Medicare fee shall be at the average wholesale price for the item less 10 percent.

(4) Payment for items with no Medicare fee, Medicaid fee, or average wholesale price shall be made at the manufacturer's suggested retail price less 15 percent.

(5) Payment for items with no Medicare fee, Medicaid fee, average wholesale price, or manufacturer's suggested retail price shall be made at the dealer's cost plus 10 percent. The actual invoice for the item from the manufacturer must be submitted with the claim. Catalog pages or printouts supplied by the provider are not considered invoices.

(6) For selected medical services, supplies, and equipment, including equipment servicing, that generally do not vary significantly in quality from one provider to another, the payment shall be the lowest price for which such devices are widely and consistently available in a locality.

(7) Payment for used equipment shall not exceed 80 percent of the purchase allowance.

(8) No allowance shall be made for delivery, freight, postage, or other provider operating expenses for durable medical equipment, prosthetic devices, or sickroom supplies.

79.1(18) Pharmaceutical case management services reimbursement. Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

<u>Service</u>	<u>Payment amount</u>	<u>Number of payments</u>
Initial assessment	\$75	One per patient
New problem assessment	\$40	Two per patient per 12 months
Problem follow-up assessment	\$40	Four per patient per 12 months
Preventative follow-up assessment	\$25	One per patient per 6 months

79.1(19) Reimbursement for translation and interpretation services. Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service. In order for translation or interpretation to be covered, it must be provided by separate employees or contractors solely performing translation or interpretation activities.

79.1(20) Dentists. The dental fee schedule is based on the definitions of dental and surgical procedures given in the Current Dental Terminology, Third Edition (CDT-3).

79.1(21) Rehabilitation agencies. Subject to the Medicaid upper limit in 79.1(2), payments to rehabilitation agencies shall be made as provided in the areawide fee schedule established for Medicare by the Centers for Medicare and Medicaid Services (CMS). The Medicare fee schedule is based on the definitions of procedures from the physicians' Current Procedural Terminology (CPT) published by the American Medical Association. CMS adjusts the fee schedules annually to reflect changes in the consumer price index for all urban customers.

79.1(22) Medicare crossover claims for inpatient and outpatient hospital services. Subject to approval of a state plan amendment by the federal Centers for Medicare and Medicaid Services, payment for crossover claims shall be made as follows.

a. Definitions. For purposes of this subrule:

“*Crossover claim*” means a claim for Medicaid payment for Medicare-covered inpatient or outpatient hospital services rendered to a Medicare beneficiary who is also eligible for Medicaid. Crossover claims include claims for services rendered to beneficiaries who are eligible for Medicaid in any category, including, but not limited to, qualified Medicare beneficiaries and beneficiaries who are eligible for full Medicaid coverage.

“*Medicaid-allowed amount*” means the Medicaid prospective reimbursement for the services rendered (including any portion to be paid by the Medicaid beneficiary as copayment or spenddown), as determined under state and federal law and policies.

“*Medicaid reimbursement*” means any amount to be paid by the Medicaid beneficiary as a Medicaid copayment or spenddown and any amount to be paid by the department after application of any applicable Medicaid copayment or spenddown.

“*Medicare payment amount*” means the Medicare reimbursement rate for the services rendered in a crossover claim, excluding any Medicare coinsurance or deductible amounts to be paid by the Medicare beneficiary.

b. Reimbursement of crossover claims. Crossover claims for inpatient or outpatient hospital services covered under Medicare and Medicaid shall be reimbursed as follows.

(1) If the Medicare payment amount for a crossover claim exceeds or equals the Medicaid-allowed amount for that claim, Medicaid reimbursement for the crossover claim shall be zero.

(2) If the Medicaid-allowed amount for a crossover claim exceeds the Medicare payment amount for that claim, Medicaid reimbursement for the crossover claim shall be the lesser of:

1. The Medicaid-allowed amount minus the Medicare payment amount; or
2. The Medicare coinsurance and deductible amounts applicable to the claim.

c. Additional Medicaid payment for crossover claims uncollectible from Medicare. Medicaid shall reimburse hospitals for the portion of crossover claims not covered by Medicaid reimbursement pursuant

to paragraph “b” and not reimbursable by Medicare as an allowable bad debt pursuant to 42 CFR 413.80, as amended June 13, 2001, up to a limit of 30 percent of the amount not paid by Medicaid pursuant to paragraph “b.” The department shall calculate these amounts for each provider on a calendar-year basis and make payment for these amounts by March 31 of each year for the preceding calendar year.

d. Application of savings. Savings in Medicaid reimbursements attributable to the limits on inpatient and outpatient crossover claims established by this subrule shall be used to pay costs associated with development and implementation of this subrule before reversion to Medicaid.

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 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

is based on a retrospective cost-related rate calculated using the methodology in this subrule. 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 one hour. EXCEPTIONS:

1. A unit of service is one day when a member receives direct supervision for 14 or more hours per day, averaged over a calendar month. The member's comprehensive service plan must identify and reflect the need for this amount of supervision. The provider's documentation must support the number of direct support hours identified in the comprehensive service plan.

2. When cost-effective, a daily rate may be developed for members needing fewer than 14 hours of direct supervision per day. The provider must obtain approval from the Iowa Medicaid enterprise for a daily rate for fewer than 14 hours of service per day.

(3) A unit of day habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

(4) A unit of prevocational habilitation is an hour, a half-day (1 to 4 hours), or a full day (4 to 8 hours).

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

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

2. One hour for enhanced job search.

(6) A unit of supported employment habilitation supports to maintain employment is one hour.

b. Submission of cost reports. 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 that meets the requirement of paragraph 79.1(24) "b," the department 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.

(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. 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.

79.1(25) Reimbursement for 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).

a. Reimbursement methodology. Effective for services rendered on or after October 1, 2006, 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) that provide clinic services are paid on a reasonable-cost basis as determined by Medicare reimbursement principles. Rates are initially paid on an interim basis and then are adjusted retroactively based on submission of a financial and statistical report.

(1) Until a provider that was enrolled into 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.

b. Reporting requirements. All providers shall submit cost reports using Form 470-4419, Financial and Statistical Report. A hospital-based provider shall also submit the Medicare cost report, CMS Form 2552-96.

(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.

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]

441—79.2(249A) Sanctions against provider of care. The department reserves the right to impose sanctions against any practitioner or provider of care who has violated the requirements for participation in the medical assistance program.

79.2(1) Definitions.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or has the power to control another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services.

"Person" means any natural person, company, firm, association, corporation, or other legal entity.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual, firm, corporation, association, or institution which is providing or has been approved to provide medical assistance to a recipient 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 withholding of all payments due a provider until the resolution of the matter in dispute between the provider 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 provider on pending and subsequently submitted bills for purposes of offsetting overpayments previously made to the provider.

79.2(2) *Grounds for sanctioning providers.* Sanctions may be imposed by the department against a provider for any one or more of the following reasons:

a. Presenting or causing to be presented for payment any false or fraudulent claim for services or merchandise.

b. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled, including charges in excess of usual and customary charges.

c. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

d. Failure to disclose or make available to the department or its authorized agent, records of services provided to medical assistance recipients and records of payments made for those services.

e. Failure to provide and maintain the quality of services to medical assistance recipients within accepted medical community standards as adjudged by professional peers.

f. Engaging in a course of conduct or performing an act which is in violation of state or federal regulations of the medical assistance program, or continuing that conduct following notification that it should cease.

g. Failure to comply with the terms of the provider certification on each medical assistance check endorsement.

h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing the recipient to receive services or merchandise not required or requested by the recipient.

i. Rebating or accepting a fee or portion of a fee or a charge for medical assistance patient referral.

j. Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto.

k. Submission of a false or fraudulent application for provider status under the medical assistance program.

l. Violations of any laws, regulations, or code of ethics governing the conduct of occupations or professions or regulated industries.

m. Conviction of a criminal offense relating to performance of a provider agreement with the state or for negligent practice resulting in death or injury to patients.

n. Failure to meet standards required by state or federal law for participation, for example, licensure.

o. Exclusion from Medicare because of fraudulent or abusive practices.

p. Documented practice of charging recipients for covered services over and above that paid for by the department, except as authorized by law.

q. Failure to correct deficiencies in provider operations after receiving notice of these deficiencies from the department.

r. Formal reprimand or censure by an association of the provider’s peers for unethical practices.

s. Suspension or termination from participation in another governmental medical program such as workers’ compensation, crippled children’s services, rehabilitation services or Medicare.

t. Indictment for fraudulent billing practices, or negligent practice resulting in death or injury to the provider’s patients.

79.2(3) *Sanctions.* The following sanctions may be imposed on providers based on the grounds specified in 79.2(2).

a. A term of probation for participation in the medical assistance program.

b. Termination from participation in the medical assistance program.

c. Suspension from participation in the medical assistance program. This includes when the department is notified by the Centers for Medicare and Medicaid Services, Department of Health and Human Services, that a practitioner has been suspended from participation under the Medicare program. These practitioners shall be suspended from participation in the medical assistance program effective

on the date established by the Centers for Medicare and Medicaid Services and at least for the period of time of the Medicare suspension.

- d. Suspension or withholding of payments to provider.
- e. Referral to peer review.
- f. Prior authorization of services.
- g. One hundred percent review of the provider's claims prior to payment.
- h. Referral to the state licensing board for investigation.
- i. Referral to appropriate federal or state legal authorities for investigation and prosecution under applicable federal or state laws.
- j. Providers with a total Medicaid credit balance of more than \$500 for more than 60 consecutive days without repaying or reaching written agreement to repay the balance shall be charged interest at 10 percent per year on each overpayment. The interest shall begin to accrue retroactively to the first full month that the provider had a credit balance over \$500.

Nursing facilities shall make repayment or reach agreement with the division of medical services. All other providers shall make repayment or reach agreement with the Iowa Medicaid enterprise. Overpayments and interest charged may be withheld from future payments to the provider.

79.2(4) Imposition and extent of sanction.

a. The decision on the sanction to be imposed shall be the commissioner's or designated representative's except in the case of a provider terminated from the Medicare program.

b. The following factors shall be considered in determining the sanction or sanctions to be imposed:

- (1) Seriousness of the offense.
- (2) Extent of violations.
- (3) History of prior violations.
- (4) Prior imposition of sanctions.
- (5) Prior provision of provider education.
- (6) Provider willingness to obey program rules.
- (7) Whether a lesser sanction will be sufficient to remedy the problem.
- (8) Actions taken or recommended by peer review groups or licensing boards.

79.2(5) Scope of sanction.

a. The sanction may be applied to all known affiliates of a provider, provided that each decision to include an affiliate is made on a case-by-case basis after giving due regard to all relevant facts and circumstances. The violation, failure, or inadequacy of performance may be imputed to a person with whom the violator is affiliated where the conduct was accomplished in the course of official duty or was effectuated with the knowledge or approval of that person.

b. Suspension or termination from participation shall preclude the provider from submitting claims for payment, whether personally or through claims submitted by any clinic, group, corporation, or other association, for any services or supplies except for those services provided before the suspension or termination.

c. No clinic, group, corporation, or other association which is the provider of services shall submit claims for payment for any services or supplies provided by a person within the organization who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.

d. When the provisions of paragraph 79.2(5) "c" are violated by a provider of services which is a clinic, group, corporation, or other association, the department may suspend or terminate the organization, or any other individual person within the organization who is responsible for the violation.

79.2(6) Notice of sanction. When a provider has been sanctioned, the department shall notify as appropriate the applicable professional society, board of registration or licensure, and federal or state agencies of the findings made and the sanctions imposed.

79.2(7) Notice of violation. Should the department have information that indicates that a provider may have submitted bills or has been practicing in a manner inconsistent with the program requirements,

or may have received payment for which the provider may not be properly entitled, the department shall notify the provider of the discrepancies noted. Notification shall set forth:

- a. The nature of the discrepancies or violations,
- b. The known dollar value of the discrepancies or violations,
- c. The method of computing the dollar value,
- d. Notification of further actions to be taken or sanctions to be imposed by the department, and
- e. Notification of any actions required of the provider. 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.

79.2(8) *Suspension or withholding of payments pending a final determination.* Where the department has notified a provider of a violation pursuant to 79.2(7) or an overpayment, the department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question or may suspend payment pending a final determination. Where the department intends to withhold or suspend payments it shall notify the provider in writing.

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

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 may 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 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.
- 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]

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 of the provider 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 surveillance and utilization review services 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, in the following format:

Iowa Department of Human Services
 Iowa Medicaid Enterprise Surveillance and Utilization Review Services
Documentation Checklist

Date of Request: _____
 Reviewer Name & Phone Number: _____
 Provider Name: _____
 Provider Number: _____
 Provider Type: _____

Please sign this form and return it with the information requested. Follow the checklist to ensure that all documents requested for each patient have been copied and enclosed with this request. The documentation must support the validity of the claim that was paid by the Medicaid program.

Please send copies. Do not send original records.

If you have any questions about this request or checklist, please contact the reviewer listed above.

	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[specific documentation required]
	[Note: number of specific documents required varies by provider type]
	Any additional documentation that demonstrates the medical necessity of the service provided or otherwise required for Medicaid payment. List additional documentation below if needed.

The person signing this form is certifying that all documentation that supports the Medicaid billed rates, units, and services is enclosed.

Signature	Title	Telephone Number
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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) Under exceptional circumstances, a provider may request one additional 15-calendar-day extension. The provider or the provider’s designee shall submit a written request that:

1. Establishes exceptional circumstances for the delay in submitting records; and
2. Is received by the department before the expiration of the initial 15-day extension period.

(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.

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.

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

441—79.5(249A) Nondiscrimination on the basis of handicap. All providers of service shall comply with Section 504 of the Rehabilitation Act of 1973 and Federal regulations 45 CFR Part 84, as amended to December 19, 1990, which prohibit discrimination on the basis of handicap in all Department of Health and Human Services funded programs.

This rule is intended to implement Iowa Code subsection 249A.4(6).

441—79.6(249A) Provider participation agreement. Providers of medical and health care wishing to participate in the program shall execute an agreement with the department on Form 470-2965, Agreement Between Provider of Medical and Health Services and the Iowa Department of Human Services Regarding Participation in Medical Assistance Program.

EXCEPTION: Dental providers are required to complete Form 470-3174, Addendum to Dental Provider Agreement for Orthodontia, to receive reimbursement under the early and periodic screening, diagnosis, and treatment program.

In these agreements, the provider agrees to the following:

79.6(1) To maintain clinical and fiscal records as specified in rule 441—79.3(249A).

79.6(2) That the charges as determined in accordance with the department's policy shall be the full and complete charge for the services provided and no additional payment shall be claimed from the recipient or any other person for services provided under the program.

79.6(3) That it is understood that payment in satisfaction of the claim will be from federal and state funds and any false claims, statements, or documents, or concealment of a material fact may be prosecuted under applicable federal and state laws.

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

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers. Officers shall be a chairperson and a vice-chairperson.

a. The director of public health shall serve as chairperson of the council. Elections for vice-chairperson will be held the first meeting after the beginning of the calendar year.

b. The vice-chairperson's term of office shall be two years. A vice-chairperson shall serve no more than two terms.

c. The vice-chairperson shall serve in the absence of the chairperson.

d. The chairperson and vice-chairperson shall have the right to vote on any issue before the council.

e. The chairperson shall appoint a committee of not less than three members to nominate vice-chairpersons and shall appoint other committees approved by the council.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

79.7(3) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

79.7(4) Meetings. The council shall meet no more than quarterly. The executive committee shall meet on a monthly basis. Meetings may be called by the chairperson, upon written request of at least 50 percent of the members, or by the director of the department of human services.

a. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given.

b. Written notice of council meetings shall be mailed at least two weeks in advance of the meeting. Each notice shall include an agenda for the meeting.

79.7(5) Procedures.

- a. A quorum shall consist of 50 percent of the voting members.
- b. Where a quorum is present, a position is carried by two-thirds of the council members present.
- c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member and to the executive office of each professional group or business entity represented.
- d. Notice shall be given to a professional group or business entity represented on the council when the representative of that group or entity has been absent from three consecutive meetings.
- e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(6) Duties.

a. *Executive committee.* Based upon the deliberations of the medical assistance advisory council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program. Such recommendations may include:

- (1) Recommendations on the reimbursement for medical services rendered by providers of services.
- (2) Identification of unmet medical needs and maintenance needs which affect health.
- (3) Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.
- (4) Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.
- (5) Advice on such administrative and fiscal matters as the director of the department of human services may request.

b. *Council.* The medical assistance advisory council shall:

- (1) Advise the professional groups and business entities represented and act as liaison between them and the department.
- (2) Report at least annually to the professional groups and business entities represented.
- (3) Perform other functions as may be provided by state or federal law or regulation.
- (4) Communicate information considered by the council to the professional groups and business entities represented.

79.7(7) Responsibilities.

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the professional groups and business entities represented. The director of the department of human services shall consider the recommendations offered by the council and the executive committee in:

- (1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3, and
- (2) Implementation of medical assistance program policies.

b. The council may choose subjects for consideration and recommendation. It shall consider all matters referred to it by the department of human services.

c. Any matter referred by a member organization or body shall be considered upon an affirmative vote of the council.

d. The department shall provide the council with reports, data, and proposed and final amendments to rules, laws, and guidelines, for its information, review, and comment.

e. The department shall present the annual budget for the medical assistance program for review and comment.

f. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

g. The department shall maintain a current list of members on the council and executive committee.

[ARC 8263B, IAB 11/4/09, effective 12/9/09]

441—79.8(249A) Requests for prior authorization. When the Iowa Medicaid enterprise has not reached a decision on a request for prior authorization after 60 days from the date of receipt, the request will be approved.

79.8(1) Making the request.

a. Providers may submit requests for prior authorization for any items or procedures by mail or by facsimile transmission (fax) using Form 470-0829, Request for Prior Authorization, or electronically using the Accredited Standards Committee (ASC) X12N 278 transaction, Health Care Services Request for Review and Response. Requests for prior authorization for drugs may also be made by telephone.

b. Providers shall send requests for prior authorization to the Iowa Medicaid enterprise. The request should address the relevant criteria applicable to the particular service, medication or equipment for which prior authorization is sought, according to rule 441—78.28(249A). Copies of history and examination results may be attached to rather than incorporated in the letter.

c. If a request for prior authorization submitted electronically requires attachments or supporting clinical documentation and a national electronic attachment has not been adopted, the provider shall:

(1) Use Form 470-3970, Prior Authorization Attachment Control, as the cover sheet for the paper attachments or supporting clinical documentation; and

(2) Reference on Form 470-3970 the attachment control number submitted on the ASC X12N 278 electronic transaction.

79.8(2) The policy applies to services or items specifically designated as requiring prior authorization.

79.8(3) The provider shall receive a notice of approval or denial for all requests.

a. In the case of prescription drugs, notices of approval or denial will be faxed to the prescriber and pharmacy.

b. Decisions regarding approval or denial will be made within 24 hours from the receipt of the prior authorization request. In cases where the request is received during nonworking hours, the time limit will be construed to start with the first hour of the normal working day following the receipt of the request.

79.8(4) Prior authorizations approved because a decision is not timely made shall not be considered a precedent for future similar requests.

79.8(5) Approved prior authorization applies to covered services and does not apply to the recipient's eligibility for medical assistance.

79.8(6) If a provider is unsure if an item or service is covered because it is rare or unusual, the provider may submit a request for prior approval in the same manner as other requests for prior approval in 79.8(1).

79.8(7) Requests for prior approval of services shall be reviewed according to rule 441—79.9(249A) and the conditions for payment as established by rule in 441—Chapter 78. Where ambiguity exists as to whether a particular item or service is covered, requests for prior approval shall be reviewed according to the following criteria in order of priority:

a. The conditions for payment outlined in the provider manual with reference to coverage and duration.

b. The determination made by the Medicare program unless specifically stated differently in state law or rule.

c. The recommendation to the department from the appropriate advisory committee.

d. Whether there are other less expensive procedures which are covered and which would be as effective.

e. The advice of an appropriate professional consultant.

79.8(8) The amount, duration and scope of the Medicaid program is outlined in 441—Chapters 78, 79, 81, 82 and 85. Additional clarification of the policies is available in the provider manual distributed and updated to all participating providers.

79.8(9) The Iowa Medicaid enterprise shall issue a notice of decision to the recipient upon a denial of request for prior approval pursuant to 441—Chapter 7. The Iowa Medicaid enterprise shall mail the

notice of decision to the recipient within five working days of the date the prior approval form is returned to the provider.

79.8(10) If a request for prior approval is denied by the Iowa Medicaid enterprise, the request may be resubmitted for reconsideration with additional information justifying the request. The aggrieved party may file an appeal in accordance with 441—Chapter 7.

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

441—79.9(249A) General provisions for Medicaid coverage applicable to all Medicaid providers and services.

79.9(1) Medicare definitions and policies shall apply to services provided unless specifically defined differently.

79.9(2) The services covered by Medicaid shall:

- a. Be consistent with the diagnosis and treatment of the patient's condition.
- b. Be in accordance with standards of good medical practice.
- c. Be required to meet the medical need of the patient and be for reasons other than the convenience of the patient or the patient's practitioner or caregiver.
- d. Be the least costly type of service which would reasonably meet the medical need of the patient.
- e. Be eligible for federal financial participation unless specifically covered by state law or rule.
- f. Be within the scope of the licensure of the provider.
- g. Be provided with the full knowledge and consent of the recipient or someone acting in the recipient's behalf unless otherwise required by law or court order or in emergency situations.
- h. Be supplied by a provider who is eligible to participate in the Medicaid program. The provider must use the billing procedures and documentation requirements described in 441—Chapters 78 and 80.

79.9(3) Providers shall supply all the same services to Medicaid eligibles served by the provider as are offered to other clients of the provider.

79.9(4) Recipients must be informed before the service is provided that the recipient will be responsible for the bill if a noncovered service is provided.

79.9(5) Coverage in public institutions. Medical services provided to a person while the person is an inmate of a public jail, prison, juvenile detention center, or other public penal institution of more than four beds are not covered by Medicaid.

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

441—79.10(249A) Requests for preadmission review. The inpatient hospitalization of Medicaid recipients is subject to preadmission review by the Iowa Medicaid enterprise (IME) medical services unit as required in rule 441—78.3(249A).

79.10(1) The patient's admitting physician, the physician's designee, or the hospital will contact the IME medical services unit to request approval of Medicaid coverage for the hospitalization, according to instructions issued to providers by the IME medical services unit and instructions in the Medicaid provider manual.

79.10(2) Medicaid payment will not be made to the hospital if the IME medical services unit denies the procedure requested in the preadmission review.

79.10(3) The IME medical services unit shall issue a letter of denial to the patient, the physician, and the hospital when a request is denied. The patient, the physician, or the hospital may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.10(4) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit according to 441—Chapter 7.

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

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

441—79.11(249A) Requests for preprocedure surgical review. The Iowa Medicaid enterprise (IME) medical services unit conducts a preprocedure review of certain frequently performed surgical procedures to determine the necessity of the procedures and if Medicaid payment will be approved according to requirements found in 441—subrules 78.1(19), 78.3(18), and 78.26(3).

79.11(1) The physician must request approval from the IME medical services unit when the physician expects to perform a surgical procedure appearing on the department's preprocedure surgical review list published in the Medicaid provider manual. All requests for preprocedure surgical review shall be made according to instructions issued to physicians, hospitals and ambulatory surgical centers appearing in the Medicaid provider manual and instructions issued to providers by the IME medical services unit.

79.11(2) The IME medical services unit shall issue the physician a validation number for each request and shall advise whether payment for the procedure will be approved or denied.

79.11(3) Medicaid payment will not be made to the physician and other medical personnel or the facility in which the procedure is performed, i.e., hospital or ambulatory surgical center, if the IME medical services unit does not give approval.

79.11(4) The IME medical services unit shall issue a denial letter to the patient, the physician, and the facility when the requested procedure is not approved. The patient, the physician, or the facility may request a reconsideration of the decision by filing a written request with the IME medical services unit within 60 days of the date of the denial letter.

79.11(5) The aggrieved party may appeal a denial of a request for reconsideration by the IME medical services unit in accordance with 441—Chapter 7.

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

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

441—79.12(249A) Advance directives. “Advance directive” means a written instruction, such as a living will or durable power of attorney for health care, recognized under state law and related to the provision of health care when the person is incapacitated. All hospitals, home health agencies, home health providers of waiver services, hospice programs, and health maintenance organizations (HMOs) participating in Medicaid shall establish policies and procedures with respect to all adults receiving medical care through the provider or organization to comply with state law regarding advance directives as follows:

79.12(1) A hospital at the time of a person's admission as an inpatient, a home health care provider in advance of a person's coming under the care of the provider, a hospice provider at the time of initial receipt of hospice care by a person, and a health maintenance organization at the time of enrollment of the person with the organization shall provide written information to each adult which explains the person's rights under state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives, and the provider's policies regarding the implementation of these rights.

79.12(2) The provider or organization shall document in the person's medical record whether or not the person has executed an advance directive.

79.12(3) The provider or organization shall not condition the provision of care or otherwise discriminate against a person based on whether or not the person has executed an advance directive.

79.12(4) The provider or organization shall ensure compliance with requirements of state law regarding advance directives.

79.12(5) The provider or organization shall provide for education for staff and the community on issues concerning advance directives.

Nothing in this rule shall be construed to prohibit the application of a state law which allows for an objection on the basis of conscience for any provider or organization which as a matter of conscience cannot implement an advance directive.

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

441—79.13(249A) Requirements for enrolled Medicaid providers supplying laboratory services. Medicaid enrolled entities providing laboratory services are subject to the provisions of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), Public Law 100-578, and implementing federal regulations published at 42 CFR Part 493 as amended to December 29, 2000. Medicaid payment shall not be afforded for services provided by an enrolled Medicaid provider supplying laboratory services that fails to meet these requirements. For the purposes of this rule, laboratory services are defined as services to examine human specimens for the diagnosis, prevention or treatment of any disease or impairment of, or assessment of, the health of human beings.

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

441—79.14(249A) Provider enrollment.

79.14(1) Application request. A provider of medical or remedial services that wishes to enroll as an Iowa Medicaid provider shall begin the enrollment process by contacting the provider services unit at the Iowa Medicaid enterprise to request an application form.

a. A nursing facility shall also complete the process set forth in 441—subrule 81.13(1).

b. An intermediate care facility for persons with mental retardation shall also complete the process set forth in 441—subrule 82.3(1).

79.14(2) Submittal of application. The provider shall submit the appropriate application forms to the Iowa Medicaid enterprise provider services unit at P.O. Box 36450, Des Moines, Iowa 50315.

a. Providers of home- and community-based waiver services shall submit Form 470-2917, Medicaid HCBS Provider Application, at least 90 days before the planned service implementation date.

b. All other providers shall submit Form 470-0254, Iowa Medicaid Provider Enrollment Application.

c. The application shall include the provider's national provider identifier number or shall indicate that the provider is an atypical provider that is not issued a national provider identifier number.

d. With the application form, an assertive community treatment program shall submit Form 470-4842, Assertive Community Services (ACT) Provider Agreement Addendum, and agree to file with the department an annual report containing information to be used for rate setting, including:

(1) Data by practitioner on the utilization by Medicaid members of all the services included in assertive community treatment, and

(2) Cost information by practitioner type and by type of service actually delivered as part of assertive community treatment.

e. With the application form, or as a supplement to a previously submitted application, providers of health home services shall submit Form 470-5100, Health Home Provider Agreement.

79.14(3) Notification. Providers shall be notified of the decision on their application by the Iowa Medicaid enterprise provider services unit within 30 calendar days.

79.14(4) Providers not approved as the type of Medicaid provider requested shall have the right to appeal under 441—Chapter 7.

79.14(5) Effective date of approval. Applications shall be approved retroactive to the date requested by the provider or the date the provider meets the applicable participation criteria, whichever is later, not to exceed 12 months retroactive from the receipt of the application forms by the Iowa Medicaid enterprise provider services unit.

79.14(6) Providers approved for certification as a Medicaid provider shall complete a provider participation agreement as required by rule 441—79.6(249A).

79.14(7) No payment shall be made to a provider for care or services provided prior to the effective date of the department's approval of an application, unless the provider was enrolled and participating in the Iowa Medicaid program as of April 1, 1993.

79.14(8) Payment rates dependent on the nature of the provider or the nature of the care or services provided shall be based on information on the application form, together with information on claim forms, or on rates paid the provider prior to April 1, 1993.

79.14(9) Amendments to application forms shall be submitted to the Iowa Medicaid enterprise provider services unit and shall be approved or denied within 30 calendar days. Approval of an

amendment shall be retroactive to the date requested by the provider or the date the provider meets all applicable criteria, whichever is later, not to exceed 30 days prior to the receipt of the amendment by the Iowa Medicaid enterprise provider services unit. Denial of an amendment may be appealed under 441—Chapter 7.

79.14(10) Providers who have not submitted claims in the last 24 months will be sent a notice asking if they wish to continue participation. Providers failing to reply to the notice within 30 calendar days of the date on the notice will be terminated as providers. Providers who do not submit any claims in 48 months will be terminated as providers without further notification.

79.14(11) Report of changes. The provider shall inform the Iowa Medicaid enterprise of all pertinent changes to enrollment information within 60 days of the change. Pertinent changes include, but are not limited to, changes to the business entity name, individual provider name, tax identification number, mailing address, and telephone number.

a. When a provider fails to provide current information within the 60-day period, the department may terminate the provider's Medicaid enrollment upon 30 days' notice. The termination may be appealed under 441—Chapter 7.

b. When the department incurs an informational tax-reporting fine because a provider submitted inaccurate information or failed to submit changes to the Iowa Medicaid enterprise in a timely manner, the fine shall be the responsibility of the individual provider to the extent that the fine relates to or arises out of the provider's failure to keep all provider information current.

(1) The provider shall remit the amount of the fine to the department within 30 days of notification by the department that the fine has been imposed.

(2) Payment of the fine may be appealed under 441—Chapter 7.

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]

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 published in the Federal Register, Vol. 75, No. 144, on July 28, 2010. 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 July 28, 2010, the department elects the calendar year preceding the payment year as the period used to calculate 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 July 28, 2010, eligible providers may elect to use either:

(1) The methodology found in 42 CFR Section 495.306(c) as amended to July 28, 2010, or

(2) The methodology found in 42 CFR Section 495.306(d) as amended to July 28, 2010.

c. For purposes of 42 CFR Section 495.310(g)(1)(i)(B) as amended to July 28, 2010, 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 July 28, 2010, 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, defined as a health care facility where the average length of stay is 25 days or fewer, which has a CMS certification number with the last four digits in the series 0001-0879 or 1300-1399.

(3) A children's hospital, defined as a separately certified children's hospital, either freestanding or a hospital-within-hospital, that predominately treats individuals under 21 years of age and has a CMS certification number with the last four digits in the series 3300-3399.

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 covered by 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 who wants to participate in the Iowa electronic health record incentive program must declare the intent to participate by registering with the National Level Repository, 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 EHR incentive payment program section of the Iowa Medicaid portal access (IMPA) Web site at <https://secureapp.dhs.state.ia.us/imp/>. 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, the eligible provider 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 National Level Repository.

a. The primary communication channel from the department to the provider will be the IMPA Web site. If the department finds that the applicant is ineligible or has failed to achieve the criteria necessary for the payment, the department shall notify the provider through the Web site. Providers shall access the Web site to determine the status of their payment, including whether the department denied payment and the reason for the denial.

b. Providers must retain records supporting their eligibility for the incentive payment for a minimum of six years. The department will select providers for audit after issuance of an incentive payment. Incentive recipients shall cooperate with the department by providing proof of:

(1) Eligibility,

(2) Purchase of certified electronic health record technology, and

(3) Meaningful use of electronic health record technology.

79.16(5) Administrative appeal. Any eligible provider or any provider that claims to be an eligible provider and who has been subject to an adverse action related to the Iowa electronic health record incentive program may seek review of the department's action pursuant to 441—Chapter 7. Appealable issues include:

- a. Provider eligibility determination.
- b. Incentive payments.
- c. Demonstration of adopting, implementing, upgrading and meaningful use of technology.

This rule is intended to implement Iowa Code section 249A.4 and Public Law No. 111-5.

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◇ Two or more ARCs

¹ Effective date of 79.1(2) and 79.1(5) "t" delayed 70 days by the Administrative Rules Review Committee at its January 1988, meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

³ Effective date of subrule 79.1(13) delayed until adjournment of the 1992 Sessions of the General Assembly by the Administrative Rules Review Committee at its meeting held July 12, 1991.

⁴ Effective date of 3/1/92 delayed until adjournment of the 1992 General Assembly by the Administrative Rules Review Committee at its meeting held February 3, 1992.

- ⁵ At a special meeting held January 24, 2002, the Administrative Rules Review Committee voted to delay until adjournment of the 2002 Session of the General Assembly the effective date of amendments published in the February 6, 2002, Iowa Administrative Bulletin as **ARC 1365B**.
- ⁶ Effective date of October 1, 2002, delayed 70 days by the Administrative Rules Review Committee at its meeting held September 10, 2002. At its meeting held November 19, 2002, the Committee voted to delay the effective date until adjournment of the 2003 Session of the General Assembly.
- ⁷ July 1, 2009, effective date of amendments to 79.1(1) "d," 79.1(2), and 79.1(24) "a"(1) delayed 70 days by the Administrative Rules Review Committee at a special meeting held June 25, 2009.
- ⁸ See HJR 2008 of 2012 Session of the Eighty-fourth General Assembly regarding nullification of amendment to 79.1(7) "b" (ARC 9959B, IAB 1/11/12).

CHAPTER 82
INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

[Prior to 7/1/83, Social Services[770] Ch 82]

[Prior to 2/11/87, Human Services[498]]

441—82.1(249A) Definition.

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

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

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

82.2(1) Governing body and management.

a. Governing body. The facility shall identify an individual or individuals to constitute the governing body of the facility. The governing body shall:

- (1) Exercise general policy, budget, and operating direction over the facility.
- (2) Set the qualifications (in addition to those already set by state law) for the administrator of the facility.
- (3) Appoint the administrator of the facility.

b. Compliance with federal, state, and local laws. The facility shall be in compliance with all applicable provisions of federal, state and local laws, regulations and codes pertaining to health, safety, and sanitation.

c. Client records.

(1) The facility shall develop and maintain a record-keeping system that includes a separate record for each client and that documents the clients’ health care, active treatment, social information, and protection of the client’s rights.

(2) The facility shall keep confidential all information contained in the clients’ records, regardless of the form or storage method of the records.

(3) The facility shall develop and implement policies and procedures governing the release of any client information, including consents necessary from the client or parents (if the client is a minor) or legal guardian.

(4) Any individual who makes an entry in a client’s record shall make it legibly, date it, and sign it.

(5) The facility shall provide a legend to explain any symbol or abbreviation used in a client’s record.

(6) The facility shall provide each identified residential living unit with appropriate aspects of each client’s record.

d. Services provided under agreements with outside sources.

(1) If a service required under this rule is not provided directly, the facility shall have a written agreement with an outside program, resource, or service to furnish the necessary service, including emergency and other health care.

(2) The agreement shall:

1. Contain the responsibilities, functions, objectives, and other terms agreed to by both parties.

2. Provide that the facility is responsible for ensuring that the outside services meet the standards for quality of services contained in this rule.

(3) The facility shall ensure that outside services meet the needs of each client.

(4) If living quarters are not provided in a facility owned by the ICF/MR, the ICF/MR remains directly responsible for the standards relating to physical environment that are specified in subrule 82.2(7), paragraphs “a” to “g,” “j,” and “k.”

e. Disclosure of ownership. The facility shall supply to the licensing agency full and complete information, and promptly report any changes which would affect the current accuracy of the information, as to identify:

(1) Each person having a direct or indirect ownership interest of 5 percent or more in the facility and the owner in whole or in part of any property or assets (stock, mortgage, deed of trust, note or other obligation) secured in whole or in part by the facility.

(2) Each officer and director of the corporation, if the facility is organized as a corporation.

(3) Each partner, if the facility is organized as a partnership.

82.2(2) Client protections.

a. Protection of clients' rights. The facility shall ensure the rights of all clients. Therefore, the facility shall:

(1) Inform each client, parent (if the client is a minor), or legal guardian of the client's rights and the rules of the facility.

(2) Inform each client, parent (if the child is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.

(3) Allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints and the right to due process.

(4) Allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.

(5) Ensure that clients are not subjected to physical, verbal, sexual, or psychological abuse or punishment.

(6) Ensure that clients are free from unnecessary drugs and physical restraints and are provided active treatment to reduce dependency on drugs and physical restraints.

(7) Provide each client with the opportunity for personal privacy and ensure privacy during treatment and care of personal needs.

(8) Ensure that clients are not compelled to perform services for the facility and ensure that clients who do work for the facility are compensated for their efforts at prevailing wages and commensurate with their abilities.

(9) Ensure clients the opportunity to communicate, associate and meet privately with individuals of their choice, and to send and receive unopened mail.

(10) Ensure that clients have access to telephones with privacy for incoming and outgoing local and long distance calls except as contraindicated by factors identified within their individual program plans.

(11) Ensure clients the opportunity to participate in social, religious, and community group activities.

(12) Ensure that clients have the right to retain and use appropriate personal possessions and clothing, and ensure that each client is dressed in the client's own clothing each day.

(13) Permit a husband and wife who both reside in the facility to share a room.

b. Client finances.

(1) The facility shall establish and maintain a system that ensures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients and precludes any commingling of client funds with facility funds or with the funds of any person other than another client.

(2) The client's financial record shall be available on request to the client, parents (if the client is a minor), or legal guardian.

c. Communication with clients, parents, and guardians. The facility shall:

(1) Promote participation of parents (if the client is a minor) and legal guardians in the process of providing active treatment to a client unless their participation is unobtainable or inappropriate.

(2) Answer communications from clients' families and friends promptly and appropriately.

(3) Promote visits by individuals with a relationship to the client (such as family, close friends, legal guardians and advocates) at any reasonable hour, without prior notice, consistent with the right of that client's and other clients' privacy, unless the interdisciplinary team determines that the visit would not be appropriate.

(4) Promote visits by parents or guardians to any area of the facility that provides direct client care services to the client, consistent with the right of that client's and other clients' privacy.

(5) Promote frequent and informal leaves from the facility for visits, trips, or vacations.

(6) Notify promptly the client's parents or guardian of any significant incidents or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.

d. Staff treatment of clients.

(1) The facility shall develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.

1. Staff of the facility shall not use physical, verbal, sexual or psychological abuse or punishment.

2. Staff shall not punish a client by withholding food or hydration that contributes to a nutritionally adequate diet.

3. The facility shall prohibit the employment of individuals with a conviction or prior employment history of child or client abuse, neglect or mistreatment.

(2) The facility shall ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with state law through established procedures.

(3) The facility shall have evidence that all alleged violations are thoroughly investigated and shall prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations shall be reported to the administrator or designated representative or to other officials in accordance with state law within five working days of the incident, and, if the alleged violation is verified, appropriate corrective action shall be taken.

82.2(3) Facility staffing.

a. Qualified mental retardation professional. Each client's active treatment program shall be integrated, coordinated and monitored by a qualified mental retardation professional who has at least one year of experience working directly with persons with mental retardation or other developmental disabilities and is one of the following:

(1) A doctor of medicine or osteopathy.

(2) A registered nurse.

(3) An individual who holds at least a bachelor's degree in a professional category specified in 82.2(3) "b"(5).

b. Professional program services.

(1) Each client shall receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Professional program staff shall work directly with clients and with paraprofessional, nonprofessional and other professional program staff who work with clients.

(2) The facility shall have available enough qualified professional staff to carry out and monitor the various professional interventions in accordance with the stated goals and objectives of every individual program plan.

(3) Professional program staff shall participate as members of the interdisciplinary team in relevant aspects of the active treatment process.

(4) Professional program staff shall participate in ongoing staff development and training in both formal and informal settings with other professional, paraprofessional, and nonprofessional staff members.

(5) Professional program staff shall be licensed, certified, or registered, as applicable, to provide professional services by the state in which the staff practices. Those professional program staff who do not fall under the jurisdiction of state licensure, certification, or registration requirements shall meet the following qualifications:

1. To be designated as an occupational therapist, an individual shall be eligible for certification as an occupational therapist by the American Occupational Therapy Association or another comparable body.

2. To be designated as an occupational therapy assistant, an individual shall be eligible for certification as an occupational therapy assistant by the American Occupational Therapy Association or another comparable body.

3. To be designated as a physical therapist, an individual shall be eligible for certification as a physical therapist by the American Physical Therapy Association or another comparable body.

4. To be designated as a physical therapy assistant, an individual shall be eligible for registration as a physical therapy assistant by the American Physical Therapy Association or be a graduate of a two-year college-level program approved by the American Physical Therapy Association or another comparable body.

5. To be designated as a psychologist, an individual shall have at least a master's degree in psychology from an accredited school.

6. To be designated as a social worker, an individual shall hold a graduate degree from a school of social work accredited or approved by the Council on Social Work Education or another comparable body or hold a bachelor of social work degree from a college or university accredited or approved by the Council on Social Work Education or another comparable body.

7. To be designated as a speech-language pathologist or audiologist, an individual shall be eligible for a Certificate of Clinical Competence in Speech-Language Pathology or Audiology granted by the American Speech-Language Hearing Association or another comparable body or meet the educational requirements for certification and be in the process of accumulating the supervised experience required for certification.

8. To be designated as a professional recreation staff member, an individual shall have a bachelor's degree in recreation or in a specialty area such as art, dance, music or physical education.

9. To be designated as a professional dietitian, an individual shall be eligible for registration by the American Dietetics Association.

10. To be designated as a human services professional, an individual shall have at least a bachelor's degree in a human services field (including, but not limited to, sociology, special education, rehabilitation counseling and psychology).

(6) If the client's individual program plan is being successfully implemented by facility staff, professional program staff meeting the qualifications of 82.2(3)"b"(5) are not required except for qualified mental retardation professionals who must meet the requirements set forth in 82.2(3)"a."

c. Facility staffing.

(1) The facility shall not depend upon clients or volunteers to perform direct care services for the facility.

(2) There shall be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: clients for whom a physician has ordered a medical care plan; clients who are aggressive, assaultive or security risks; more than 16 clients; or fewer than 16 clients within a multi-unit building.

(3) There shall be a responsible direct care staff person on duty on a 24-hour basis, when clients are present, to respond to injuries and symptoms of illness, and to handle emergencies, in each defined residential living unit housing: clients for whom a physician has not ordered a medical care plan; clients who are not aggressive, assaultive or security risks; and 16 or fewer clients.

(4) The facility shall provide sufficient support staff so that direct care staff are not required to perform support services to the extent that these duties interfere with the exercise of their primary direct client care duties.

d. Direct care (residential living unit) staff.

(1) The facility shall provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

(2) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.

(3) Direct care staff shall be provided by the facility in the following minimum ratios of direct care staff to clients:

1. For each defined residential living unit serving children under the age of 12, severely and profoundly retarded clients, clients with severe physical disabilities, or clients who are aggressive,

assaultive, or security risks, or who manifest severely hyperactive or psychotic-like behavior, the staff-to-client ratio is 1 to 3.2.

2. For each defined residential living unit serving moderately retarded clients, the staff-to-client ratio is 1 to 4.

3. For each defined residential living unit serving clients who function within the range of mild retardation, the staff-to-client ratio is 1 to 6.4.

4. When there are no clients present in the living unit, a responsible staff member must be available by telephone.

e. Staff training program.

(1) The facility shall provide each employee with initial and continuing training that enables the employee to perform the employee's duties effectively, efficiently, and competently.

(2) For employees who work with clients, training shall focus on skills and competencies directed toward clients' developmental, behavioral, and health needs.

(3) Staff shall be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.

(4) Staff shall be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible.

82.2(4) Active treatment services.

a. Active treatment.

(1) Each client shall receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this paragraph, that is directed toward: the acquisition of the behaviors necessary for the client to function with as much self-determination and independence as possible; and the prevention or deceleration of regression or loss of current optimal functional status.

(2) Active treatment does not include services to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.

b. Admissions, transfers, and discharge.

(1) Clients who are admitted by the facility shall be in need of and receiving active treatment services.

(2) Admission decisions shall be based on a preliminary evaluation of the client that is conducted or updated by the facility or by outside sources.

(3) A preliminary evaluation shall contain background information as well as currently valid assessments of functional developmental, behavioral, social, health and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

(4) If a client is to be either transferred or discharged, the facility shall have documentation in the client's record that the client was transferred or discharged for good cause, and shall provide a reasonable time to prepare the client and the client's parents or guardian for the transfer or discharge (except in emergencies).

(5) At the time of the discharge, the facility shall develop a final summary of the client's developmental, behavioral, social, health and nutritional status and, with the consent of the client, parents (if the client is a minor) or legal guardian, provide a copy to authorized persons and agencies, and shall provide a post-discharge plan of care that will assist the client to adjust to the new living environment.

c. Individual program plan.

(1) Each client shall have an individual program plan developed by an interdisciplinary team that represents the professions, disciplines or service areas that are relevant to identifying the client's needs, as described by the comprehensive functional assessments required in 82.2(4) "c"(3), and designing programs that meet the client's needs.

(2) Appropriate facility staff shall participate in interdisciplinary team meetings. Participation by other agencies serving the client is encouraged. Participation by the client, the client's parents (if the

client is a minor), or the client's legal guardian is required unless that participation is unobtainable or inappropriate.

(3) Within 30 days after admission, the interdisciplinary team shall perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The comprehensive functional assessment shall take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable, and shall:

1. Identify the presenting problems and disabilities and, where possible, their causes.
2. Identify the client's specific developmental strengths.
3. Identify the client's specific developmental and behavioral management needs.
4. Identify the client's need for services without regard to the actual availability of the services needed.
5. Include physical development and health, nutritional status, sensorimotor development, affective development, speech and language development and auditory functioning, cognitive development, social development, adaptive behaviors or independent living skills necessary for the client to be able to function in the community, and, as applicable, vocational skills.

(4) Within 30 days after admission, the interdisciplinary team shall prepare for each client an individual program plan that states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by 82.2(4) "c"(3), and the planned sequence for dealing with those objectives. These objectives shall:

1. Be stated separately, in terms of a single behavioral outcome.
2. Be assigned projected completion dates.
3. Be expressed in behavioral terms that provide measurable indices of performance.
4. Be organized to reflect a developmental progression appropriate to the individual.
5. Be assigned priorities.

(5) Each written training program designed to implement the objectives in the individual program plan shall specify:

1. The methods to be used.
2. The schedule for use of the method.
3. The person responsible for the program.
4. The type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.
5. The inappropriate client behaviors, if applicable.
6. Provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.

(6) The individual program plan shall also:

1. Describe relevant interventions to support the individual toward independence.
2. Identify the location where program strategy information (which shall be accessible to any person responsible for implementation) can be found.
3. Include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.
4. Identify mechanical supports, if needed, to achieve proper body position, balance, or alignment. The plan shall specify the reason for each support, the situations in which each is to be applied, and a schedule for the use of each support.
5. Provide that clients who have multiple disabling conditions spend a major portion of each waking day out of bed and outside the bedroom area, moving about by various methods and devices whenever possible.
6. Include opportunities for client choice and self-management.

(7) A copy of each client's individual program plan shall be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.

d. Program implementation.

(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client shall receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.

(2) The facility shall develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.

(3) Except for those facets of the individual program plan that must be implemented only by licensed personnel, each client's individual program plan shall be implemented by all staff who work with the client, including professional, paraprofessional and nonprofessional staff.

e. Program documentation.

(1) Data relative to accomplishment of the criteria specified in client individual program plan objectives shall be documented in measurable terms.

(2) The facility shall document significant events that are related to the client's individual program plan and assessments and that contribute to an overall understanding of the client's ongoing level and quality of functioning.

f. Program monitoring and change.

(1) The individual program plan shall be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to, situations in which the client:

1. Has successfully completed an objective or objectives identified in the individual program plan.
2. Is regressing or losing skills already gained.
3. Is failing to progress toward identified objectives after reasonable efforts have been made.
4. Is being considered for training toward new objectives.

(2) At least annually, the comprehensive functional assessment of each client shall be reviewed by the interdisciplinary team for relevancy and updated as needed, and the individual program plan shall be revised, as appropriate, repeating the process set forth in 82.2(4) "c."

(3) The facility shall designate and use a specially constituted committee or committees consisting of members of facility staff, parents, legal guardians, clients (as appropriate), qualified persons who have either experience or training in contemporary practices to change inappropriate client behavior, and persons with no ownership or controlling interest in the facility to:

1. Review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights.
2. Ensure that these programs are conducted only with the written informed consent of the client, parent (if the client is a minor), or legal guardian.
3. Review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other area that the committee believes needs to be addressed.

(4) The provisions of 82.2(4) "f"(3) may be modified only if, in the judgment of the department of inspections and appeals, court decrees, state law or regulations provide for equivalent client protection and consultation.

82.2(5) Client behavior and facility practices.

a. Facility practices—conduct toward clients.

(1) The facility shall develop and implement written policies and procedures for the management of conduct between staff and clients. These policies and procedures shall:

1. Promote the growth, development and independence of the client.
2. Address the extent to which client choice will be accommodated in daily decision making, emphasizing self-determination and self-management, to the extent possible.
3. Specify client conduct to be allowed or not allowed.

4. Be available to all staff, clients, parents of minor children, and legal guardians.
- (2) To the extent possible, clients shall participate in the formulation of these policies and procedures.
- (3) Clients shall not discipline other clients, except as part of an organized system of self-government, as set forth in facility policy.
- b. Management of inappropriate client behavior.*
 - (1) The facility shall develop and implement written policies and procedures that govern the management of inappropriate client behavior. These policies and procedures shall be consistent with the provisions of 82.2(5) "a." These procedures shall:
 1. Specify all facility-approved interventions to manage inappropriate client behavior.
 2. Designate these interventions on a hierarchy to be implemented ranging from most positive or least intrusive to least positive or most intrusive.
 3. Ensure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and have been demonstrated to be ineffective.
 4. Address the use of time-out rooms, the use of physical restraints, the use of drugs to manage inappropriate behavior, the application of painful or noxious stimuli, the staff members who may authorize the use of specified interventions, and a mechanism for monitoring and controlling the use of these interventions.
 - (2) Interventions to manage inappropriate client behavior shall be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of clients are adequately protected.
 - (3) Techniques to manage inappropriate client behavior shall never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program.
 - (4) The use of systematic interventions to manage inappropriate client behavior shall be incorporated into the client's individual program plan, in accordance with 82.2(4) "c"(4) and (5).
 - (5) Standing or as-needed programs to control inappropriate behavior are not permitted.
- c. Time-out rooms.*
 - (1) A client may be placed in a room from which egress is prevented only if the following conditions are met:
 1. The placement is a part of an approved systematic time-out program as required by 82.2(5) "b."
 2. The client is under the direct constant visual supervision of designated staff.
 3. The door to the room is held shut by staff or by a mechanism requiring constant physical pressure from a staff member to keep the mechanism engaged.
 - (2) Placement of a client in a time-out room shall not exceed one hour.
 - (3) Clients placed in time-out rooms shall be protected from hazardous conditions including, but not limited to, presence of sharp corners and objects, uncovered light fixtures, unprotected electrical outlets.
 - (4) A record of time-out activities shall be kept.
- d. Physical restraints.*
 - (1) The facility may employ physical restraint only:
 1. As an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.
 2. As an emergency measure, but only if absolutely necessary to protect the client or others from injury.
 3. As a health-related protection prescribed by a physician, but only if absolutely necessary during the conduct of a specific medical or surgical procedure, or only if absolutely necessary for client protection during the time that a medical condition exists.
 - (2) Authorizations to use or extend restraints as an emergency shall be in effect no longer than 12 consecutive hours and shall be obtained as soon as the client is restrained or stable.
 - (3) The facility shall not issue orders for restraint on a standing or as-needed basis.

(4) A client placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, shall be released from the restraint as quickly as possible, and a record of these checks and usage shall be kept.

(5) Restraints shall be designated and used so as not to cause physical injury to the client and so as to cause the least possible discomfort.

(6) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two-hour period in which restraint is employed, and a record of the activity shall be kept.

(7) Barred enclosures shall not be more than three feet in height and shall not have tops.

e. Drug usage.

(1) The facility shall not use drugs in doses that interfere with the individual client's daily living activities.

(2) Drugs used for control of inappropriate behavior shall be approved by the interdisciplinary team and be used only as an integral part of the client's individual program plan that is directed specifically toward the reduction and eventual elimination of the behaviors for which the drugs are employed.

(3) Drugs used for control of inappropriate behavior shall not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs.

(4) Drugs used for control of inappropriate behavior shall be monitored closely, in conjunction with the physician and the drug regimen review requirement at 82.2(6) "j," for desired responses and adverse consequences by facility staff, and shall be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.

82.2(6) Health care services.

a. Physician services.

(1) The facility shall ensure the availability of physician services 24 hours a day.

(2) The physician shall develop, in coordination with licensed nursing personnel, a medical care plan of treatment for a client if the physician determines that an individual client requires 24-hour licensed nursing care. This plan shall be integrated in the individual program plan.

(3) The facility shall provide or obtain preventive and general medical care as well as annual physical examinations of each client that at a minimum include the following:

1. Evaluation of vision and hearing.

2. Immunizations, using as a guide the recommendations of the Public Health Service Advisory Committee on Immunization Practices or of the Committee on the Control of Infectious Diseases of the American Academy of Pediatrics.

3. Routine screening laboratory examinations as determined necessary by the physician, and special studies when needed.

4. Tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section of diseases of the chest of the American Academy of Pediatrics, or both.

(4) To the extent permitted by state law, the facility may utilize physician assistants and nurse practitioners to provide physician services as described in this subrule.

b. Physician participation in the individual program plan. A physician shall participate in:

(1) The establishment of each newly admitted client's initial individual program plan.

(2) If appropriate, physicians shall participate in the review and update of an individual program plan as part of the interdisciplinary team process either in person or through written report to the interdisciplinary team.

c. Nursing services. The facility shall provide clients with nursing services in accordance with their needs. These services shall include:

(1) Participation as appropriate in the development, review, and update of an individual program plan as part of the interdisciplinary team process.

(2) The development, with a physician, of a medical care plan of treatment for a client when the physician has determined that an individual client requires such a plan.

(3) For those clients certified as not needing a medical care plan, a review of their health status which shall:

1. Be by a direct physical examination.
2. Be by a licensed nurse.
3. Be on a quarterly or more frequent basis depending on client need.
4. Be recorded in the client's record.
5. Result in any necessary action including referral to a physician to address client health problems.

(4) Other nursing care as prescribed by the physician or as identified by client needs.

(5) Implementing, with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to:

1. Training clients and staff as needed in appropriate health and hygiene methods.
2. Control of communicable diseases and infections, including the instruction of other personnel in methods of infection control.
3. Training direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.

d. Nursing staff.

(1) Nurses providing services in the facility shall have a current license to practice in the state.

(2) The facility shall employ or arrange for licensed nursing services sufficient to care for clients' health needs including those clients with medical care plans.

(3) The facility shall utilize registered nurses as appropriate and required by state law to perform the health services specified in this subrule.

(4) If the facility utilizes only licensed practical or vocational nurses to provide health services, it shall have a formal arrangement with a registered nurse to be available for verbal or on-site consultation with the licensed practical or vocational nurse.

(5) Nonlicensed nursing personnel who work with clients under a medical care plan shall do so under the supervision of licensed persons.

e. Dental services.

(1) The facility shall provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists, either through organized dental services in-house or through arrangement.

(2) If appropriate, dental professionals shall participate in the development, review and update of an individual program plan as part of the interdisciplinary process either in person or through written report to the interdisciplinary team.

(3) The facility shall provide education and training in the maintenance of oral health.

f. Comprehensive dental diagnostic services. Comprehensive dental diagnostic services include:

(1) A complete extraoral and intraoral examination, using all diagnostic aids necessary to properly evaluate the client's oral condition, not later than one month after admission to the facility unless the examination was completed within 12 months before admission.

(2) Periodic examination and diagnosis performed at least annually, including radiographs when indicated and detection of manifestations of systemic disease.

(3) A review of the results of examination and entry of the results in the client's dental record.

g. Comprehensive dental treatment. The facility shall ensure comprehensive dental treatment services that include:

(1) The availability for emergency dental treatment on a 24-hour-a-day basis by a licensed dentist.

(2) Dental care needed for relief of pain and infections, restoration of teeth and maintenance of dental health.

h. Documentation of dental services.

(1) If the facility maintains an in-house dental service, the facility shall keep a permanent dental record for each client, with a dental summary maintained in the client's living unit.

(2) If the facility does not maintain an in-house dental service, the facility shall obtain a dental summary of the results of dental visits and maintain the summary in the client's living unit.

i. Pharmacy services. The facility shall provide or make arrangements for the provision of routine and emergency drugs and biologicals to its clients. Drugs and biologicals may be obtained from community or contract pharmacists or the facility may maintain a licensed pharmacy.

j. Drug regimen review.

(1) A pharmacist with input from the interdisciplinary team shall review the drug regimen of each client at least quarterly.

(2) The pharmacist shall report any irregularities in clients' drug regimens to the prescribing physician and interdisciplinary team.

(3) The pharmacist shall prepare a record of each client's drug regimen reviews and the facility shall maintain that record.

(4) An individual medication administration record shall be maintained for each client.

(5) As appropriate, the pharmacist shall participate in the development, implementation, and review of each client's individual program plan either in person or through written report to the interdisciplinary team.

k. Drug administration. The facility shall have an organized system for drug administration that identifies each drug up to the point of administration. The system shall ensure that:

(1) All drugs are administered in compliance with the physician's orders.

(2) All drugs, including those that are self-administered, are administered without error.

(3) Unlicensed personnel are allowed to administer drugs only if state law permits.

(4) Clients are taught how to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise.

(5) The client's physician is informed of the interdisciplinary team's decision that self-administration of medications is an objective for the client.

(6) No client self-administers medications until the client demonstrates the competency to do so.

(7) Drugs used by clients while not under the direct care of the facility are packaged and labeled in accordance with state law.

(8) Drug administration errors and adverse drug reactions are recorded and reported immediately to a physician.

l. Drug storage and record keeping.

(1) The facility shall store drugs under proper conditions of sanitation, temperature, light, humidity, and security.

(2) The facility shall keep all drugs and biologicals locked except when being prepared for administration. Only authorized persons may have access to the keys to the drug storage area. Clients who have been trained to self-administer drugs in accordance with 82.2(6) "k"(4) may have access to keys to their individual drug supply.

(3) The facility shall maintain records of the receipt and disposition of all controlled drugs.

(4) The facility shall, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in Schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq.).

(5) If the facility maintains a licensed pharmacy, the facility shall comply with the regulations for controlled drugs.

m. Drug labeling.

(1) Labeling of drugs and biologicals shall be based on currently accepted professional principles and practices, and shall include the appropriate accessory and cautionary instructions, as well as the expiration date, if applicable.

(2) The facility shall remove from use outdated drugs and drug containers with worn, illegible, or missing labels.

(3) Drugs and biologicals packaged in containers designated for a particular client shall be immediately removed from the client's current medication supply if discontinued by the physician.

n. Laboratory services.

(1) For purposes of this subrule, “laboratory” means an entity for the microbiological, serological, chemical, hematological, radiobioassay, cytological, immunohematological, pathological or other examination of materials derived from the human body, for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or assessment of a medical condition.

(2) If a facility chooses to provide laboratory services, the laboratory shall meet the management requirements specified in 42 CFR 493.1407 and provide personnel to direct and conduct the laboratory services.

The laboratory director shall be technically qualified to supervise the laboratory personnel and test performance and shall meet licensing or other qualification standards established by the state with respect to directors of clinical laboratories.

The laboratory director shall provide adequate technical supervision of the laboratory services and ensure that tests, examinations and procedures are properly performed, recorded and reported.

The laboratory director shall ensure that the staff has appropriate education, experience, and training to perform and report laboratory tests promptly and proficiently; is sufficient in number for the scope and complexity of the services provided; and receives in-service training appropriate to the type of complexity of the laboratory services offered.

The laboratory technologists shall be technically competent to perform test procedures and report test results promptly and proficiently.

(3) The laboratory shall meet the proficiency testing requirements specified in 42 CFR 493.801.

(4) The laboratory shall meet the quality control requirements specified in 42 CFR 493.1501.

(5) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be an approved Medicare laboratory.

82.2(7) Physical environment.

a. Client living environment.

(1) The facility shall not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, blind, or have seizure disorders with others of comparable social and intellectual development.

b. Client bedrooms.

(1) Bedrooms shall:

1. Be rooms that have at least one outside wall.

2. Be equipped with or located near toilet and bathing facilities.

3. Accommodate no more than four clients unless granted a variance under 82.2(7)“b”(3).

4. Measure at least 60 square feet per client in multiple-client bedrooms and at least 80 square feet in single-client bedrooms.

5. In all facilities initially certified or in buildings constructed or with major renovations or conversions, have walls that extend from floor to ceiling.

(2) If a bedroom is below grade level, it shall have a window that is usable as a second means of escape by the client occupying the rooms and shall be no more than 44 inches measured to the windowsill above the floor unless the facility is surveyed under the Health Care Occupancy Chapter of the Life Safety Code, in which case the window must be no more than 36 inches measured to the windowsill above the floor.

(3) The department of inspections and appeals may grant a variance from the limit of four clients per room only if a physician who is a member of the interdisciplinary team and who is a qualified mental retardation professional certifies that each client to be placed in a bedroom housing more than four persons is so severely medically impaired as to require direct and continuous monitoring during sleeping hours and documents the reasons why housing in a room of only four or fewer persons would not be medically feasible.

(4) The facility shall provide each client with:

1. A separate bed of proper size and height for the convenience of the client.

2. A clean, comfortable mattress.
3. Bedding appropriate to the weather and climate.
4. Functional furniture appropriate to the client's needs, and individual closet space in the client's bedroom with clothes racks and shelves accessible to the client.

c. Storage space in bedroom. The facility shall provide:

(1) Space and equipment for daily out-of-bed activity for all clients who are not yet mobile, except those who have a short-term illness or those few clients for whom out-of-bed activity is a threat to health and safety.

(2) Suitable storage space, accessible to clients, for personal possessions such as televisions, radios, prosthetic equipment and clothing.

d. Client bathrooms. The facility shall:

(1) Provide toilet and bathing facilities appropriate in number, size, and design to meet the needs of the clients.

(2) Provide for individual privacy in toilets, bathtubs, and showers.

(3) In areas of the facility where clients who have not been trained to regulate water temperature are exposed to hot water, ensure that the temperature of the water does not exceed 110 degrees Fahrenheit.

e. Heating and ventilation.

(1) Each client bedroom in the facility shall have at least one window to the outside and direct outside ventilation by means of windows, air conditioning, or mechanical ventilation.

(2) The facility shall maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means and ensure that the heating apparatus does not constitute a burn or smoke hazard to clients.

f. Floors. The facility shall have:

(1) Floors that have a resilient, nonabrasive, and slip-resistant surface.

(2) Nonabrasive carpeting, if the area used by clients is carpeted and serves clients who lie on the floor or ambulate with parts of their bodies, other than feet, touching the floor.

(3) Exposed floor surfaces and floor coverings that promote mobility in areas used by clients, and promote maintenance of sanitary conditions.

g. Space and equipment. The facility shall:

(1) Provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this rule and as identified in each client's individual program plan.

(2) Furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.

(3) Provide adequate clean linen and dirty linen storage areas.

h. Emergency plan and procedures.

(1) The facility shall develop and implement detailed written plans and procedures to meet all potential emergencies and disasters such as fire, severe weather, and missing clients.

(2) The facility shall communicate, periodically review, make the plan available, and provide training to the staff.

i. Evacuation drills.

(1) The facility shall hold evacuation drills at least quarterly for each shift of personnel and under varied conditions to ensure that all personnel on all shifts are trained to perform assigned tasks; ensure that all personnel on all shifts are familiar with the use of the facility's fire protection features; and evaluate the effectiveness of emergency and disaster plans and procedures.

(2) The facility shall actually evacuate clients during at least one drill each year on each shift; make special provisions for the evacuation of clients with physical disabilities; file a report and evaluation on each evacuation drill; and investigate all problems with evacuation drills, including accidents, and take corrective action. During fire drills, clients may be evacuated to a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.

(3) Facilities shall meet the requirements of 82.2(7) "i"(1) and (2) for any live-in and relief staff they utilize.

j. Fire protection.

(1) General.

1. Except as specified in 82.2(7) "i"(2), the facility shall meet the applicable provisions of either the Health Care Occupancies Chapters or the Residential Board and Care Occupancies Chapter of the Life Safety Code (LSC) of the National Fire Protection Association, 1985 edition, which is incorporated by reference.

2. The department of inspections and appeals may apply a single chapter of the LSC to the entire facility or may apply different chapters to different buildings or parts of buildings as permitted by the LSC.

3. A facility that meets the LSC definition of a residential board and care occupancy and that has 16 or fewer beds shall have its evacuation capability evaluated in accordance with the Evacuation Difficulty Index of the LSC (Appendix F).

(2) Exceptions.

1. For facilities that meet the LSC definition of a health care occupancy, the Centers for Medicare and Medicaid Services may waive, for a period it considers appropriate, specific provisions of the LSC if the waiver would not adversely affect the health and safety of the clients and rigid application of specific provisions would result in an unreasonable hardship for the facility.

The department of inspections and appeals may apply the state's fire and safety code instead of the LSC if the Secretary of the Department of Health and Human Services finds that the state has a code imposed by state law that adequately protects a facility's clients.

Compliance on November 28, 1982, with the 1967 edition of the LSC or compliance on April 18, 1986, with the 1981 edition of the LSC, with or without waivers, is considered to be compliance with this standard as long as the facility continues to remain in compliance with that edition of the code.

2. For facilities that meet the LSC definition of a residential board and care occupancy and that have more than 16 beds, the department of inspections and appeals may apply the state's fire and safety code as specified above.

k. Paint. The facility shall:

(1) Use lead-free paint inside the facility.

(2) Remove or cover interior paint or plaster containing lead so that it is not accessible to clients.

l. Infection control.

(1) The facility shall provide a sanitary environment to avoid sources and transmission of infections. There shall be an active program for the prevention, control, and investigation of infection and communicable diseases.

(2) The facility shall implement successful corrective action in affected problem areas.

(3) The facility shall maintain a record of incidents and corrective actions related to infections.

(4) The facility shall prohibit employees with symptoms or signs of a communicable disease from direct contact with clients and their food.

82.2(8) *Dietetic services.*

a. Food and nutrition services.

(1) Each client shall receive a nourishing, well-balanced diet including modified and specially prescribed diets.

(2) A qualified dietitian shall be employed either full-time, part-time or on a consultant basis at the facility's discretion.

(3) If a qualified dietitian is not employed full-time, the facility shall designate a person to serve as the director of food services.

(4) The client's interdisciplinary team, including a qualified dietitian and physician, shall prescribe all modified and special diets including those used as a part of a program to manage inappropriate client behavior.

(5) Foods proposed for use as a primary reinforcement of adaptive behavior are evaluated in light of the client's nutritional status and needs.

(6) Unless otherwise specified by medical needs, the diet shall be prepared at least in accordance with the latest edition of the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences, adjusted for age, sex, disability and activity.

b. Meal services.

(1) Each client shall receive at least three meals daily, at regular times comparable to normal mealtimes in the community with:

1. Not more than 14 hours between a substantial evening meal and breakfast of the following day, except on weekends and holidays when a nourishing snack is provided at bedtime, 16 hours may elapse between a substantial evening meal and breakfast.

2. Not less than 10 hours between breakfast and the evening meal of the same day, except as provided under 82.2(8)“b”(1)“1.”

(2) Food shall be served:

1. In appropriate quantity.

2. At appropriate temperature.

3. In a form consistent with the developmental level of the client.

4. With appropriate utensils.

(3) Food served to clients individually and uneaten shall be discarded.

c. Menus.

(1) Menus shall:

1. Be prepared in advance.

2. Provide a variety of foods at each meal.

3. Be different for the same days of each week and adjusted for seasonal change.

4. Include the average portion sizes for menu items.

(2) Menus for food actually served shall be kept on file for 30 days.

d. Dining areas and service. The facility shall:

(1) Serve meals for all clients, including persons with ambulation deficits, in dining areas, unless otherwise specified by the interdisciplinary team or a physician.

(2) Provide table service for all clients who can and will eat at a table, including clients in wheelchairs.

(3) Equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.

(4) Supervise and staff dining rooms adequately to direct self-help dining procedure, to ensure that each client receives enough food and to ensure that each client eats in a manner consistent with the client's developmental level.

(5) Ensure that each client eats in an upright position, unless otherwise specified by the interdisciplinary team or physician.

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

441—82.3(249A) Conditions of participation for intermediate care facilities for the mentally retarded. All intermediate care facilities for the mentally retarded must enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program.

82.3(1) Procedures for establishing health care facilities as Title XIX facilities. All survey procedures and the certification process shall be in accordance with Department of Health and Human Services publication “Providers Certification State Operations Manual.”

a. The facility shall obtain the applicable license from the department of inspections and appeals.

b. The facility shall request an application, Form 470-0254, Iowa Medicaid Provider Enrollment Application, from the Iowa Medicaid enterprise provider services unit.

c. The department shall transmit an application form and copies of standards to the facility.

d. The facility shall complete its portion of the application form and submit it to the department.

e. The department shall review the application form and forward it to the department of inspections and appeals.

- f.* The department of inspections and appeals shall schedule and complete a survey of the facility.
- g.* The department of inspections and appeals shall notify the facility of any deficiencies and ask for a plan for the correction of the deficiencies.
- h.* The facility shall submit a plan of correction within ten days after receipt of written deficiencies from the health facilities division, department of inspections and appeals. This plan must be approved before the facility can be certified.
- i.* The department of inspections and appeals shall evaluate the survey findings and plan of correction and either recommend the facility for certification or recommend denial of certification. The date of certification will be the date of approval of the plan of corrections.
- j.* When certification is recommended, the department of inspections and appeals shall notify the department recommending terms and conditions of a provider agreement.
- k.* The department shall review the certification data and:
 - (1) Transmit the provider agreement as recommended, or
 - (2) Transmit the provider agreement for a term less than recommended by the department of inspections and appeals or elect not to execute an agreement for reasons of good cause as defined in 82.3(2) "c."

82.3(2) Title XIX provider agreements. The health care facility must be recommended for certification by the Iowa department of inspections and appeals for participation as an intermediate care facility for the mentally retarded before a provider agreement may be issued. All survey procedures and certification processes shall be in accordance with Department of Health and Human Services publication "Providers Certification State Operations Manual." The effective date of a provider agreement may not be earlier than the date of certification.

- a.* Terms of the agreement for facilities without deficiencies are as follows:
 - (1) The provider agreement shall be issued for a period not to exceed 12 months.
 - (2) The provider agreement shall be for the term of and in accordance with the provisions of certification, except that for good cause, the department may elect to execute an agreement for a term less than the period of certification, elect not to execute an agreement for reasons of good cause, or cancel an agreement.
- b.* Terms of the agreement for facilities with deficiencies are as follows:
 - (1) A new provider agreement may be executed for a period not to exceed 60 days from the time required to correct deficiencies up to a period of 12 months.
 - (2) A new provider agreement may be issued for a period of up to 12 months subject to automatic cancellation 60 days following the scheduled date for correction unless required corrections have been completed or unless the survey agency finds and notifies the department that the facility has made substantial progress in correcting the deficiencies and has resubmitted in writing a new plan of correction acceptable to the survey agency.
 - (3) There will be no new agreement when the facility continues to be out of compliance with the same standard(s) at the end of the term of agreement.
- c.* The department may, for good cause, elect not to execute an agreement. Good cause shall be defined as a continued or repeated failure to operate an intermediate care facility for the mentally retarded in compliance with rules and regulations of the program.
- d.* The department may at its option extend an agreement with a facility for two months under either of the following conditions:
 - (1) The health and safety of the residents will not be jeopardized thereby and the extension is necessary to prevent irreparable harm to the facility or hardship to the resident.
 - (2) It is impracticable to determine whether the facility is complying with the provisions and requirements of the provider agreement.
- e.* When it becomes necessary for the department to cancel or refuse to renew a Title XIX provider agreement, federal financial participation may continue for 30 days beyond the date of cancellation if the extension is necessary to ensure the orderly transfer of residents.
- f.* When the department of inspections and appeals survey indicates deficiencies in the areas of the Life Safety Code (LSC) or environment and sanitation, a timetable detailing corrective measures shall be

submitted to the department of inspections and appeals before a provider agreement can be issued. This timetable shall not exceed two years from the date of initial certification and shall detail corrective steps to be taken and when corrections will be accomplished. The following shall apply in these instances.

(1) The department of inspections and appeals shall determine that the facility can make corrections within the two-year period.

(2) During the period allowed for corrections, the facility shall be in compliance with existing state fire safety and sanitation codes and regulations.

(3) The facility shall be surveyed at least semiannually until corrections are completed. The facility must have made substantial effort and progress in its plan of correction as evidenced by work orders, contracts, or other evidence.

82.3(3) Appeals of decertification. A facility may appeal a decertification action according to 441—subrule 81.13(28).

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

441—82.4 Rescinded, effective March 1, 1987.

441—82.5(249A) Financial and statistical report. All facilities wishing to participate in the program shall submit a Financial and Statistical Report, Form 470-0030, to the department. These reports shall be based on the following rules.

82.5(1) Failure to maintain records. Failure to maintain and submit adequate accounting or statistical records shall result in termination or suspension of participation in the program.

82.5(2) Accounting procedures. Financial information shall be based on that appearing in the audited financial statement. Adjustments to convert to the accrual basis of accounting shall be made when the records are maintained on other accounting bases. Facilities which are a part of a larger health facility extending short-term, intensive, or other health care not generally considered nursing care may submit a cost apportionment schedule prepared in accordance with recognized methods and procedures. The schedule shall be required when necessary for a fair presentation of expense attributable to intermediate care facility patients.

82.5(3) Submission of reports. The facility's cost report shall be submitted to the department no later than September 30 each year except as described in subrule 82.5(14). Failure to submit the report within this time shall reduce payment to 75 percent of the current rate. The reduced rate shall be paid for no longer than three months, after which time no further payments will be made.

82.5(4) Payment at new rate. When a new rate is established, payment at the new rate shall be effective with services rendered as of the first day of the month in which the report is postmarked, or if the report was personally delivered, the first day of the month in which the report was received by the department. Adjustments shall be included in the payment the third month after the receipt of the report.

82.5(5) Accrual basis. Facilities not using the accrual basis of accounting shall adjust recorded amounts to the accrual basis. Expenses which pertain to an entire year shall be properly amortized by month in order to be properly recorded for the annual fiscal year report. Records of cash receipts and disbursements shall be adjusted to reflect accruals of income and expense.

82.5(6) Census of Medicaid members. Census figures of Medicaid members shall be obtained on the last day of the month ending the reporting period.

82.5(7) Patient days. In determining inpatient days, a patient day is that period of service rendered a patient between the census-taking hours on two successive days, the day of discharge being counted only when the patient was admitted that same day.

82.5(8) Opinion of accountant. The department may require that an opinion of a certified public accountant or public accountant accompany the report when adjustments made to prior reports indicate disregard of the certification and reporting instructions.

82.5(9) Calculating patient days. When calculating patient days, facilities shall use an accumulation method.

a. Census information shall be based on a patient status at midnight each day. A patient whose status changes from one class to another shall be shown as discharged from the previous status and admitted to the new status on the same day.

b. When a member is on a reserve bed status and the department is paying on a per diem basis for the holding of a bed, or any day a bed is reserved for a public assistance or nonpublic assistance patient and a per diem rate for the bed is charged to any party, the reserved days shall be included in the total census figures for inpatient days.

82.5(10) Revenues. Revenues shall be reported as recorded in the general books and records. Expense recoveries credited to expense accounts shall not be reclassified in order to be reflected as revenues.

a. Routine daily services shall represent the established charge for daily care. Routine daily services are those services which include room, board, nursing services, and such services as supervision, feeding, incontinency, and similar services, for which the associated costs are in nursing service.

b. Revenue from ancillary services provided to patients shall be applied in reduction of the related expense.

c. Revenue from the sale of medical supplies, food or services to employees or nonresidents of the facility shall be applied in reduction of the related expense. Revenue from the sale to private-pay residents of items or services which are included in the medical assistance per diem will not be offset.

d. Investment income adjustment is necessary only when interest expense is incurred, and only to the extent of the interest expense.

e. Laundry revenue shall be applied to laundry expense.

f. Accounts receivable charged off or provision for uncollectible accounts shall be reported as a deduction from gross revenue.

82.5(11) Limitation of expenses. Certain expenses that are not normally incurred in providing patient care shall be eliminated or limited according to the following rules.

a. Federal and state income taxes are not allowed as reimbursable costs. These taxes are considered in computing the fee for services for proprietary institutions.

b. Fees paid directors and nonworking officer's salaries are not allowed as reimbursable costs.

c. Personal travel and entertainment are not allowed as reimbursable costs. Certain expenses such as rental or depreciation of a vehicle and expenses of travel which include both business and personal shall be prorated. Amounts that appear excessive may be limited after considering the specific circumstances. Records shall be maintained to substantiate the indicated charges.

d. Loan acquisition fees and standby fees are not considered part of the current expense of patient care, but should be amortized over the life of the related loan.

e. A reasonable allowance of compensation for services of owners or immediate relatives is an allowable cost, provided the services are actually performed in a necessary function. For this purpose, the following persons are considered immediate relatives: husband and wife; natural parent, child and sibling; adopted child and adoptive parent; stepparent, stepchild, stepbrother and stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, and sister-in-law; grandparent and grandchild. Adequate time records shall be maintained. Adjustments may be necessary to provide compensation as an expense for nonsalaried working proprietors and partners. Members of religious orders serving under an agreement with their administrative office are allowed salaries paid persons performing comparable services. When maintenance is provided these persons by the facility, consideration shall be given to the value of these benefits and this amount shall be deducted from the amount otherwise allowed for a person not receiving maintenance.

(1) Compensation means the total benefit received by the owner or immediate relative for services rendered. It includes salary amounts paid for managerial, administrative, professional, and other services; amounts paid by the facility for the personal benefit of the proprietor or immediate relative; the cost of assets and services which the proprietor or immediate relative receives from the facility; and deferred compensation.

(2) Reasonableness—requires that the compensation allowance be such an amount as would ordinarily be paid for comparable services by comparable institutions, and depends upon the facts and circumstances of each case.

(3) Necessary—requires that the function be such that had the owner or immediate relative not rendered the services, the facility would have had to employ another person to perform the service, and be pertinent to the operation and sound conduct of the institution.

(4) The base maximum allowed compensation for an administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is \$1,926 per month plus \$20.53 per month per licensed bed capacity for each bed over 60, not to exceed \$2,852 per month. An administrator is considered to be involved in ownership of a facility when the administrator has ownership interest of 5 percent or more.

On a semiannual basis, the maximum allowed compensation amounts for these administrators shall be increased or decreased by the inflation factor applied to facility rates.

(5) The maximum allowed compensation for an assistant administrator who is involved in ownership of the facility or who is an immediate relative of an owner of the facility in facilities having a licensed capacity of 151 or more beds is 60 percent of the amount allowed for the administrator. An assistant administrator is considered to be involved in ownership of a facility when the assistant administrator has ownership interest of 5 percent or more.

(6) The maximum allowed compensation for a director of nursing or any employee who is involved in ownership of the facility or who is an immediate relative of an owner of the facility is 60 percent of the amount allowed for the administrator. Persons involved in ownership or relatives providing professional services shall be limited to rates prevailing in the community not to exceed 60 percent of the allowable rate for the administrator on a semiannual basis. Records shall be maintained in the same manner for an employee involved in ownership as are maintained for any employee of the facility. Ownership is defined as an interest of 5 percent or more.

f. Management fees and home office costs shall be allowed only to the extent that they are related to patient care and replace or enhance but do not duplicate functions otherwise carried out in a facility.

g. Depreciation based upon tax cost using only the straight-line method of computation, recognizing the estimated useful life of the asset as defined in the American Hospital Association Useful Life Guide, may be included as a patient cost. When accelerated methods of computation have been elected for income tax purposes, an adjustment shall be made. For change of ownership, refer to subrule 82.5(12).

h. Necessary and proper interest on both current and capital indebtedness is an allowable cost.

(1) Interest is the cost incurred for the use of borrowed funds. Interest on current indebtedness is the cost incurred for funds borrowed for a relatively short term. Interest on capital indebtedness is the cost incurred for funds borrowed for capital purposes.

(2) “Necessary” requires that the interest be incurred on a loan made to satisfy a financial need of the provider, be incurred on a loan made for a purpose reasonably related to patient care, and be reduced by investment income except where the income is from gifts and grants whether restricted or unrestricted, and which are held separate and not commingled with other funds.

(3) “Proper” requires that interest be incurred at a rate not in excess of what a prudent borrower would have had to pay in the money market on the date the loan was made, and be paid to a lender not related through control or ownership to the borrowing organization.

(4) Interest on loans is allowable as cost at a rate not in excess of the amount an investor could receive on funds invested in the locality on the date the loan was made.

(5) Interest is an allowable cost when the general fund of a provider borrows from a donor-restricted fund, a funded depreciation account of the provider, or the provider’s qualified pension fund, and pays interest to the fund, or when a provider operated by members of a religious order borrows from the order.

(6) When funded depreciation is used for purposes other than improvement, replacement or expansion of facilities or equipment related to patient care, allowable interest expense is reduced to adjust for offsets not made in prior years for earnings on funded depreciation. A similar treatment will

be accorded deposits in the provider's qualified pension fund where the deposits are used for other than the purpose for which the fund was established.

i. Costs applicable to supplies furnished by a related party or organization are a reimbursable cost when included at the cost to the related party or organization. The cost shall not exceed the price of comparable supplies that could be purchased elsewhere.

(1) Related means that the facility, to a significant extent, is associated with or has control of or is controlled by the organization furnishing the services, facilities, or supplies.

(2) Common ownership exists when an individual or individuals possess significant ownership or equity in the facility and the institution or organization serving the provider.

(3) Control exists where an individual or an organization has power, directly or indirectly, to significantly influence or direct the actions or policies of an organization or institution.

(4) When the facility demonstrates by convincing evidence that the supplying organization is a bona fide separate organization; that a substantial part of its business activity of the type carried on with the facility is transacted with others and there is an open competitive market for the type of services, facilities, or supplies furnished by the organization; that the services, facilities, or supplies are those which commonly are obtained by similar institutions from other organizations and are not a basic element of patient care ordinarily furnished directly to patients by the institutions; and that the charge to the facility is in line with the charge for services, facilities, or supplies in the open market and no more than the charge made under comparable circumstances to others by the organization for the services, facilities, or supplies, the charges by the supplier shall be allowable costs.

j. A facility entering into a new or renewed rent or lease agreement on or after June 1, 1994, shall be subject to the provisions of this paragraph.

When the operator of a participating facility rents from a nonrelated party, the amount of rent expense allowable on the cost report shall be the lesser of the actual rent payments made under the terms of the lease or an annual reasonable rate of return applied to the cost of the facility. The cost of the facility shall be determined as the historical cost of the facility in the hands of the owner when the facility first entered the Iowa Medicaid program. Where the facility has previously participated in the program, the cost of the facility shall be determined as the historical cost of the facility, as above, less accumulated depreciation claimed for cost reimbursement under the program. The annual reasonable rate of return shall be defined as one and one-half times the annualized interest rate of 30-year Treasury bonds as reported by the Federal Reserve Board on a weekly-average basis, at the date the lease was entered into.

When the operator of a participating facility rents the building from a related party, the amount of rent expense allowable on the cost report shall be limited to the lesser of the actual rent payments made under the terms of the lease or the amount of property costs that would otherwise have been allowable under the Iowa Medicaid program to an owner-provider of that facility.

The lessee shall submit a copy of the lease agreement, documentation of the cost basis used and a schedule demonstrating that the limitations have been met with the first cost report filed for which lease costs are claimed.

k. Each facility which supplies transportation services as defined in Iowa Code section 324A.1, subsection 1, shall provide current documentation of compliance with or exemption from public transit coordination requirements as found in Iowa Code chapter 324A and department of transportation rules 761—Chapter 910 at the time of annual contract renewal. Failure to cooperate in obtaining or in providing the required documentation of compliance or exemption after receipt from the Iowa department of transportation, public transit division, shall result in disallowance of vehicle costs and other costs associated with transporting residents.

l. Depreciation, interest and other capital costs attributable to construction of new facilities, expanding existing facilities, or the purchase of an existing facility, are allowable expenses only if prior approval has been gained through the health planning process specified in rules of the public health department, 641—Chapter 201.

m. Reasonable legal fees are an allowable cost when directly related to patient care. Legal fees related to defense against threatened state license revocation or Medicaid decertification are allowable

costs only up to the date a final appeal decision is issued. However, in no case will legal fees related to Medicaid decertification be allowable costs for more than 120 days following the decertification date.

82.5(12) Termination or change of owner.

a. A participating facility contemplating termination of participation or negotiating a change of ownership shall provide the department with at least 60 days' prior notice. A transfer of ownership or operation terminates the participation agreement. A new owner or operator shall establish that the facility meets the conditions for participation and enter into a new agreement. The person responsible for transfer of ownership or for termination is responsible for submission of a final financial and statistical report through the date of the transfer. No payment to the new owner will be made until formal notification is received. The following situations are defined as a transfer of ownership:

(1) In the case of a partnership which is a party to an agreement to participate in the medical assistance program, the removal, addition, or substitution of an individual for a partner in the association, in the absence of an express statement to the contrary, dissolves the old partnership and creates a new partnership which is not a party to the previously executed agreement and a transfer of ownership has occurred.

(2) When a participating nursing home is a sole proprietorship, a transfer of title and property to another party constitutes a change of ownership.

(3) When the facility is a corporation, neither a transfer of corporate stock nor a merger of one or more corporations with the participating corporation surviving is a transfer of ownership. A consolidation of two or more corporations resulting in the creation of a new corporate entity constitutes a change of ownership.

(4) When a participating facility is leased, a transfer of ownership is considered to have taken place. When the entire facility is leased, the total agreement with the lessor terminates. When only part of the facility is leased, the agreement remains in effect with respect to the unleased portion, but terminates with respect to the leased portion.

b. No increase in the value of the property shall be allowed in determining the Medicaid rate for the new owner with any change of ownership (including lease agreements). When filing the first cost report, the new owner shall either continue the schedule of depreciation and interest established by the previous owner, or the new owner may choose to claim the actual rate of interest expense. The results of the actual rate of interest expense shall not be higher than would be allowed under the Medicare principles of reimbursement and shall be applied to the allowed depreciable value established by the previous owner, less any down payment made by the new owner.

c. Other acquisition costs of the new owner such as legal fees, accounting and administrative costs, travel costs and the costs of feasibility studies attributable to the negotiation or settlement of the sale or purchase of the property shall not be allowed.

d. In general, the provisions of Section 1861(v)(1)(0) of the Social Security Act regarding payment allowed under Medicare principles of reimbursement at the time of a change of ownership shall be followed, except that no return on equity or recapture of depreciation provisions shall be employed.

e. A new owner or lessee wishing to claim a new rate of interest expense must submit documentation which verifies the amount of down payment made, the actual rate of interest, and the number of years required for repayment with the next semiannual cost report. In the absence of the necessary supportive documentation, interest and other property costs for all facilities which have changed or will change ownership shall continue at the rate allowed the previous owner.

82.5(13) Assessed fee. The fee assessed pursuant to 441—Chapter 36 shall be an allowable cost for cost reporting and audit purposes.

a. For the purpose of implementing the assessment for facilities operated by the state, Medicaid reimbursement rates shall be recalculated effective October 1, 2003, as provided in paragraph "*b.*"

b. For purposes of determining rates paid for services rendered after October 1, 2003, each state-operated facility's annual costs for periods before implementation of the assessment shall be increased by an amount equal to 6 percent of the facility's annual revenue for the preceding fiscal year.

82.5(14) Payment to new facility. A facility receiving Medicaid ICF/MR certification on or after July 1, 1992, shall be subject to the provisions of this subrule.

a. A facility receiving initial Medicaid certification for ICF/MR level of care shall submit a budget for six months of operation beginning with the month in which Medicaid certification is given. The budget shall be submitted at least 30 days in advance of the anticipated certification date. The Medicaid per diem rate for a new facility shall be based on the submitted budget subject to review by the accounting firm under contract with the department. The rate shall be subject to a maximum set at the eightieth percentile of all participating community-based Iowa ICFs/MR with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year. The state hospital schools shall not be included in the compilation of facility costs. The beginning rates for a new facility shall be effective with the date of Medicaid certification.

b. Initial cost report. Following six months of operation as a Medicaid-certified ICF/MR, the facility shall submit a report of actual costs. The rate computed from this cost report shall be adjusted to 100 percent occupancy plus the annual percentage increase of the Consumer Price Index for all urban consumers, U.S. city average (hereafter referred to as the Consumer Price Index). For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used to adjust costs for inflation, instead of the annual percentage increase of the Consumer Price Index. Business start-up and organization costs shall be accounted for in the manner prescribed by the Medicare and Medicaid standards. Any costs that are properly identifiable as start-up costs, organization costs or capitalizable as construction costs must be appropriately classified as such.

(1) Start-up costs. In the period of developing a provider's ability to furnish patient care services, certain costs are incurred. The costs incurred during this time of preparation are referred to as start-up costs. Since these costs are related to patient care services rendered after the time of preparation, the costs must be capitalized as deferred charges and amortized over a five-year period.

Start-up costs include, for example, administrative and program staff salaries, heat, gas and electricity, taxes, insurance, mortgage and other interest, employee training costs, repairs and maintenance, and housekeeping.

(2) Organization costs. Organization costs are those costs directly related to the creation of a corporation or other form of business. These costs are an intangible asset in that they represent expenditures for rights and privileges which have a value to the enterprise. The services inherent in organization costs extend over more than one accounting period and affect the costs of future periods of operation. Organization costs must be amortized over a five-year period.

1. Allowable organization costs. Allowable organization costs include, but are not limited to, legal fees incurred in establishing the corporation or other organization (such as drafting the corporate charter and bylaws, legal agreements, minutes of organization meetings, terms of original stock certificates), necessary accounting fees, expenses of temporary directors and organizational meetings of directors and stockholders, and fees paid to states for incorporation.

2. Unallowable organization costs. The following types of costs are not considered allowable organization costs: costs relating to the issuance and sale of shares of capital stock or other securities, such as underwriters' fees and commissions, accountant's or lawyer's fees; costs of qualifying the issues with the appropriate state or federal authorities; and stamp taxes.

c. Standardization of cost reporting period for new facilities.

(1) Facilities receiving initial certification between July 1 and December 31 (inclusive) shall submit three successive six-month cost reports covering their first 18 months of operation. The fourth six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(2) Facilities receiving initial certification between January 1 and June 30 (inclusive) shall submit two successive six-month cost reports covering the first 12 months of operation. The third six-month cost report shall cover the January 1 to June 30 period. Thereafter, the facility shall submit a cost report on an annual basis of July 1 to June 30.

(3) All facilities shall comply with the requirements of subrule 82.5(3) when submitting reports.

d. Completion of 12 months of operation. Following the first 12 months of operation as a Medicaid-certified ICF/MR as described in subrule 82.5(14), the facility shall submit a cost report for the second six months of operation. An on-site audit of facility costs shall be performed by the

accounting firm under contract with the department. Based on the audited cost report, a rate shall be established for the facility. This rate shall be considered the base rate until rebasing of facility costs occurs.

(1) A new maximum allowable base cost will be calculated each year by increasing the prior year's maximum allowable base by the annual percentage increase of the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the prior year's maximum allowable base cost shall be increased by 3 percent, instead of the annual percentage increase of the Consumer Price Index.

(2) Each year's maximum allowable base cost represents the maximum amount that can be reimbursed.

e. Maximum rate. Facilities shall be subject to a maximum rate set at the eightieth percentile of the total per diem cost of all participating community-based ICFs/MR with established base rates. The eightieth percentile maximum rate shall be adjusted July 1 of each year using cost reports on file December 31 of the previous year.

f. Incentive factor. New facilities which complete the second annual period of operation that have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index, as described in 82.5(14) "d," shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem cost for the annual period just completed is the incentive factor. For the period beginning July 1, 2009, and ending June 30, 2010, the incentive factor shall be calculated using 3 percent in place of the percentage increase of the Consumer Price Index.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the next annual period of operation.

(2) Facilities whose annual per unit cost decreased from the prior year shall be given their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment.

g. Reimbursement for first annual period. The reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

(3) All calculated per diem rates shall be subject to the prevailing maximum rate.

82.5(15) Payment to new owner. An existing facility with a new owner shall continue with the previous owner's per diem rate until a new financial and statistical report has been submitted and a new rate established according to subrule 82.5(16). The facility may submit a report for the period of July 1 to June 30 or may submit two cost reports within the fiscal year provided the second report covers a period of at least six months ending on the last day of the fiscal year. The facility shall notify the department of the reporting option selected.

82.5(16) Payment to existing facilities. The following reimbursement limits shall apply to all non-state-owned ICFs/MR:

a. Each facility shall file a cost report covering the period from January 1, 1992, to June 30, 1992. This cost report shall be used to establish a reimbursement rate to be paid to the facility and shall be used to establish the base allowable cost per unit to be used in future reimbursement rate calculations. Subsequent cost reports shall be filed annually by each facility covering the 12 months from July 1 to June 30.

b. The reimbursement rate established based on the report covering January 1, 1992, to June 30, 1992, shall be calculated using the method in place prior to July 1, 1992, including inflation and incentive factors.

c. The audited per unit cost from the January 1, 1992, to June 30, 1992, cost report shall become the initial allowable base cost. A new maximum allowable base cost will be calculated each year as described in 82.5(14) "d."

d. Facilities which have an annual per unit cost percentage increase of less than the percentage increase of the Consumer Price Index or of less than 3 percent for rates effective July 1, 2009, through June 30, 2010, shall be given their actual percentage increase plus one-half the difference of their actual percentage increase compared to the allowable maximum percentage increase. This percentage difference multiplied by the actual per diem costs for the annual period just completed is the incentive factor.

(1) The incentive factor will be added to the new reimbursement base rate to be used as the per diem rate for the following annual period.

(2) Facilities whose annual per unit cost decreased from the prior year shall receive their actual per unit cost plus one and one-half the percentage increase in the Consumer Price Index as an incentive for cost containment. For the period beginning July 1, 2009, and ending June 30, 2010, 3 percent shall be used in lieu of the percentage increase in the Consumer Price Index.

e. Administrative costs shall not exceed 18 percent of total facility costs. Administrative costs are comprised of those costs incurred in the general management and administrative functions of the facility. Administrative costs include, but are not necessarily limited to, the administrative portion of the following:

- (1) Administrator's salary.
- (2) Assistant administrator's salary.
- (3) Bookkeeper's salary.
- (4) Other accounting and bookkeeping costs.
- (5) Other clerical salaries and clerical costs.
- (6) Administrative payroll taxes.
- (7) Administrative unemployment taxes.
- (8) Administrative group insurance.
- (9) Administrative general liability and worker's compensation insurance.
- (10) Directors' and officers' insurance or salaries.
- (11) Management fees.
- (12) Indirect business expenses and other costs related to the management of the facility including home office and other organizational costs.
- (13) Legal and professional fees.
- (14) Dues, conferences and publications.
- (15) Postage and telephone.
- (16) Administrative office supplies and equipment, including depreciation, rent, repairs, and maintenance as documented by a supplemental schedule which identifies the portion of repairs and maintenance, depreciation, and rent which applies to office supplies and equipment.
- (17) Data processing and bank charges.
- (18) Advertising.
- (19) Travel, entertainment and vehicle expenses not directly involving residents.

f. Facility rates shall be rebased using the cost report for the year covering state fiscal year 1996 and shall subsequently be rebased each four years. The department shall consider allowing special rate adjustments between rebasing cycles if:

- (1) An increase in the minimum wage occurs.
- (2) A change in federal regulations occurs which necessitates additional staff or expenditures for capital improvements, or a change in state or federal law occurs, or a court order with force of law mandates program changes which necessitate the addition of staff or other resources.
- (3) A decision is made by a facility to serve a significantly different client population or to otherwise make a dramatic change in program structure (documentation and verification will be required).
- (4) A facility increases or decreases licensed bed capacity by 20 percent or more.

g. Total patient days for purposes of the computation shall be inpatient days as determined in subrule 82.5(7) or 80 percent of the licensed capacity of the facility, whichever is greater. The reimbursement rate shall be determined by dividing total reported patient expenses by total patient days during the reporting period. This cost per day will be limited by an inflation increase which shall not exceed the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, the inflation increase shall be 3 percent, notwithstanding the percentage change in the Consumer Price Index.

h. State-owned ICFs/MR shall submit semiannual cost reports and shall receive semiannual rate adjustments based on actual costs of operation inflated by the percentage change in the Consumer Price Index. For the period beginning July 1, 2009, and ending June 30, 2010, costs of operation shall be inflated by 3 percent instead of the percentage change in the Consumer Price Index.

i. The projected reimbursement for the first annual period will be determined by multiplying the per diem rate calculated for the base period by the Consumer Price Index plus one.

(1) The projected reimbursement for each period thereafter (until rebasing) will be calculated by multiplying the lower of the prior year's actual or the projected reimbursement per diem by the Consumer Price Index plus one. For the period beginning July 1, 2009, and ending June 30, 2010, the projected reimbursement will be determined using a multiplier of 3 percent instead of the Consumer Price Index.

(2) If a facility experiences an increase in actual costs that exceeds both the actual reimbursement and the maximum allowable base cost as determined for that annual period, the facility shall receive as reimbursement in the following period the maximum allowable base as calculated.

This rule is intended to implement Iowa Code sections 249A.12 and 249A.16.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.6(249A) Eligibility for services.

82.6(1) *Interdisciplinary team.* The initial evaluation for admission shall be conducted by an interdisciplinary team. The team shall consist of a physician, a social worker, and other professionals. At least one member of the team shall be a qualified mental retardation professional.

82.6(2) *Evaluation.* The evaluation shall include a comprehensive medical, social, and psychological evaluation. The comprehensive evaluation shall include:

a. Diagnoses, summaries of present medical, social and where appropriate, developmental findings, medical and social family history, mental and physical functional capacity, prognoses, range of service needs, and amounts of care required.

b. An evaluation of the resources available in the home, family, and community.

c. An explicit recommendation with respect to admission or in the case of persons who make application while in the facility, continued care in the facility. Where it is determined that intermediate care facility for the mentally retarded services are required by an individual whose needs might be met through the use of alternative services which are currently unavailable, this fact shall be entered in the record, and plans shall be initiated for the active exploration of alternatives.

d. An individual plan for care shall include diagnosis, symptoms, complaints or complications indicating the need for admission, a description of the functional level of the resident; written objective; orders as appropriate for medications, treatments, restorative and rehabilitative services, therapies, diet, activities, social services, and special procedures designed to meet the objectives; and plans for continuing care, including provisions for review and necessary modifications of the plan, and discharge.

e. Written reports of the evaluation and the written individual plan of care shall be delivered to the facility and entered in the individual's record at the time of admission or, in the case of individuals already in the facility, immediately upon completion.

82.6(3) *Certification statement.* Eligible individuals may be admitted to an intermediate care facility for the mentally retarded upon the certification of a physician that there is a necessity for care at the facility. Eligibility shall continue as long as a valid need for the care exists.

82.6(4) Rescinded IAB 4/9/97, effective 6/1/97.

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

441—82.7(249A) Initial approval for ICF/ID care.

82.7(1) Referral through targeted case management. Persons seeking ICF/ID placement shall be referred through targeted case management. The case management program shall:

- a. Identify appropriate service alternatives;
- b. Inform the person of the alternatives; and
- c. Refer a person without appropriate alternatives to the department.

82.7(2) Approval of placement by department.

a. Within 30 days of receipt of a referral, the department shall:

- (1) Approve ICF/ID placement;
- (2) Offer a home- or community-based alternative; or
- (3) Refer the person back to the targeted case management program for further consideration of service needs.

b. Once ICF/ID placement is approved, the eligible person, or the person's representative, is free to seek placement in the facility of the person's or the person's representative's choice.

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

82.7(4) Appeal rights. Notice of adverse action and right to appeal shall be given in accordance with 441—Chapter 7.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10; ARC 0191C, IAB 7/11/12, effective 7/1/12]

441—82.8(249A) Determination of need for continued stay. Certification of need for continued stay shall be made according to procedures established by the Iowa Medicaid enterprise (IME) medical services unit.

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

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.9(249A) Arrangements with residents.

82.9(1) Resident care agreement. The ICF/MR Resident Care Agreement, Form 470-0374, shall be used as a three-party contract among the facility, the resident, and the department to spell out the duties, rights, and obligation of all parties.

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

82.9(3) Personal needs account. When a facility manages the personal needs funds of a resident, it shall establish and maintain a system of accounting for expenditures from the resident's personal needs funds. The department shall charge back to the facility any maintenance item included in the computation of the audit cost that is charged to the resident's personal needs account when the charge constitutes double payment. Unverifiable expenditures charged to personal needs accounts may be charged back to the facility. The accounting system is subject to audit by representatives of the department of inspections and appeals and shall meet the following criteria:

a. Upon admittance, a ledger sheet shall be credited with the resident's total incidental money on hand. Thereafter, the ledger shall be kept current on a monthly basis. The facility may combine the accounting with the disbursement section showing the date, amount given the resident, and the resident's signature. A separate ledger shall be maintained for each resident.

b. When something is purchased for the resident and is not a direct cash disbursement, each expenditure item in the ledger shall be supported by a signed, dated receipt. The receipt shall indicate the article furnished for the resident's benefit.

c. Personal funds shall only be turned over to the resident, the resident's guardian, or other persons selected by the resident. With the consent of the resident, when the resident is able and willing to give consent, the administrator may turn over personal funds to a close relative or friend of the resident to purchase a particular item. A signed, itemized, dated receipt shall be required to be deposited in the resident's files.

d. The receipts for each resident shall be kept until canceled by auditors.

e. The ledger and receipts for each resident shall be made available for periodic audits by an accredited department of inspections and appeals representative. Audit certification shall be made by the department's representative at the bottom of the ledger sheet. Supporting receipts may then be destroyed.

f. Upon a member's death, a receipt shall be obtained from the next of kin or the member's guardian before releasing the balance of the personal needs funds. When the member has been receiving a grant from the department for all or part of the personal needs, any funds shall revert to the department. The department shall turn the funds over to the member's estate.

82.9(4) *Safeguarding personal property.* The facility shall safeguard the resident's personal possessions. Safeguarding shall include, but is not limited to:

a. Providing a method of identification of the resident's suitcases, clothing, and other personal effects, and listing these on an appropriate form attached to the resident's record at the time of admission. These records shall be kept current. Any personal effects released to a relative of the resident shall be covered by a signed receipt.

b. Providing adequate storage facilities for the resident's personal effects.

c. Ensuring that the resident is accorded privacy and uncensored communication with others by mail and telephone and with persons of the resident's choice except when therapeutic or security reasons dictate otherwise. Any limitations or restrictions imposed shall be approved by the administrator and the reasons noted shall be made a part of the resident's record.

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

[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.10(249A) Discharge and transfer.

82.10(1) *Notice.* When a Medicaid member requests transfer or discharge to a community setting, or another person requests this for the member, the administrator shall promptly notify a targeted case management provider. Names of local providers are available from the department's local office. This shall be done in sufficient time to permit a case manager to assist in the decision and planning for the transfer or discharge.

82.10(2) *Case activity report.* A Case Activity Report, Form 470-0042, shall be submitted to the department whenever a Medicaid applicant or member enters the facility, changes level of care, or is discharged from the facility.

82.10(3) *Plan.* The administrator and staff shall assist the resident in planning for transfer or discharge through development of a discharge plan.

82.10(4) *Transfer records.* When a resident is transferred to another facility, transfer information shall be summarized from the facility's records in a copy to accompany the resident. This information shall include:

a. A transfer form of diagnosis.

b. Aid to daily living information.

c. Transfer orders.

d. Nursing care plan.

e. Physician's or qualified mental retardation professional's orders for care.

f. The resident's personal records.

g. When applicable, the personal needs fund record.

82.10(5) *Income refund.* When a resident leaves the facility during the month, any unused portion of the resident's income shall be refunded.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.11(249A) *Continued stay review.* The Iowa Medicaid enterprise (IME) medical services unit shall be responsible for reviews of each resident's need for continuing care in intermediate care facilities for the mentally retarded.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.12(249A) *Quality of care review.* The Iowa Medicaid enterprise (IME) medical services unit shall carry out the quality of care studies in intermediate care facilities for the mentally retarded.

This rule is intended to implement Iowa Code section 249A.12.
[ARC 8207B, IAB 10/7/09, effective 12/1/09; ARC 8446B, IAB 1/13/10, effective 2/17/10]

441—82.13(249A) *Records.*

82.13(1) *Content.* The facility shall as a minimum maintain the following records:

a. All records required by the department of public health and the department of inspections and appeals.

b. Medical records as required by Section 1902(a)(31) of Title XIX of the Social Security Act.

c. Records of all treatments, drugs and services for which vendors' payments have been made or are to be made under the medical assistance program, including the authority for and the date of administration of the treatment, drugs, or services.

d. Documentation in each resident's records which will enable the department to verify that each charge is due and proper prior to payment.

e. Financial records maintained in the standard, specified form including the facility's most recent audited cost report.

f. All other records as may be found necessary by the department in determining compliance with any federal or state law or rule or regulation promulgated by the United States Department of Health and Human Services or by the department.

g. Census records to include the date, number of residents at the beginning of each day, names of residents admitted, and names of residents discharged.

(1) Census information shall be provided for residents in skilled, intermediate, and residential care.

(2) Census figures for each type of care shall be totaled monthly to indicate the number admitted, the number discharged, and the number of patient days.

(3) Failure to maintain acceptable census records shall result in the per diem rate being computed on the basis of 100 percent occupancy and a request for refunds covering indicated recipients of nursing care which have not been properly accounted for.

h. Resident accounts.

i. Inservice education program records.

j. Inspection reports pertaining to conformity with federal, state, and local laws.

k. Residents' personal records.

l. Residents' medical records.

m. Disaster preparedness reports.

82.13(2) *Retention.* Records shall be retained in the facility for a minimum of five years or until an audit is performed on those records, whichever is longer.

82.13(3) *Change of owner.* All records shall be retained within the facility upon change of ownership.

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

441—82.14(249A) Payment procedures.

82.14(1) *Method of payment.* Facilities shall be reimbursed under a cost-related vendor payment program. A per diem rate shall be established based on information submitted according to rule 441—82.5(249A).

82.14(2) *Payment responsibility.* Rescinded IAB 7/11/12, effective 7/1/12.

82.14(3) Rescinded IAB 8/9/89, effective 10/1/89.

82.14(4) *Periods authorized for payment.*

a. Payment shall be made on a per diem basis for the portion of the month the resident is in the facility.

b. Payment will be authorized as long as the resident is certified as needing care in an intermediate care facility for the mentally retarded.

c. Payment will be approved for the day of admission but not the day of discharge or death.

d. Payment will be approved for periods the resident is absent to visit home for a maximum of 30 days annually. Additional days may be approved for special programs of evaluation, treatment or habilitation outside the facility. Documentation as to the appropriateness and therapeutic value of resident visits and outside programming, signed by a physician or qualified mental retardation professional, shall be maintained at the facility.

e. Payment will be approved for a period not to exceed ten days in any calendar month when the resident is absent due to hospitalization. Medicaid payment to the facility may not be initiated while a resident is on reserve bed days unless the person was residing in the facility as a private pay resident prior to the hospitalization and returns to the facility as a resident.

f. Payment for periods when residents are absent for visitation or hospitalization from facilities with more than 15 beds will be made at 80 percent of the allowable audited costs for those beds. Facilities with 15 or fewer beds will be reimbursed at 95 percent of the allowable audited costs for those beds.

82.14(5) *Supplementation.* Only the amount of client participation may be billed to the resident for the cost of care. No supplementation of the state payment shall be made by any person.

EXCEPTION: The resident, the resident's family or friends may pay to hold the resident's bed in cases where a resident spends over 30 days on yearly visitation or spends over 10 days on a hospital stay. When the resident is not discharged from the facility, the payments shall not exceed 80 percent of the allowable audited costs for the facility, not to exceed the maximum reimbursement rate. When the resident is discharged, the facility may handle the holding of the reserved bed in the same manner as a private paying resident.

82.14(6) *Payment for out-of-state care.* Rescinded IAB 9/5/90, effective 11/1/90.

This rule is intended to implement Iowa Code section 249A.12 as amended by 2012 Iowa Acts, Senate File 2336, section 58.

[ARC 0191C, IAB 7/11/12, effective 7/1/12]

441—82.15(249A) Billing procedures.

82.15(1) *Claims.* Claims for service must be sent to the Iowa Medicaid enterprise after the month of service and within 365 days of the date of service. Claims may be submitted electronically on software provided by the Iowa Medicaid enterprise or in writing on Form 470-0039, Iowa Medicaid Long-Term Care Claim.

a. When payment is made, the facility will receive a copy of Form 470-0039. The white copy of the original shall be returned as a claim for the next month. If the claim is submitted electronically, the facility will receive a remittance statement of the claims paid.

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

82.15(2) Reserved.

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

441—82.16(249A) Closing of facility. When a facility is planning on closing, the department shall be notified at least 60 days in advance of the closing. Plans for the transfer of residents receiving Medicaid shall be approved by the county office of the department.

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

441—82.17(249A) Audits.

82.17(1) Audits of financial and statistical report. Authorized representatives of the department or the Department of Health and Human Services shall have the right, upon proper identification, to audit, using generally accepted auditing procedures, the general financial records of a facility to determine if expenses reported on the Financial and Statistical Report, Form 470-0030, are reasonable and proper according to the rules set forth in 441—82.5(249A). These audits may be done either on the basis of an on-site visit to the facility, their central accounting office, or office(s) of their agents.

a. When a proper per diem rate cannot be determined, through generally accepted auditing procedures, the auditor shall examine and adjust the report to arrive at what appears to be an acceptable rate and shall recommend to the department that the indicated per diem should be reduced to 75 percent of the established payment rate for the ensuing fiscal period and if the situation is not remedied on the subsequent Financial and Statistical Report, Form 470-0030, the facility shall be suspended and eventually canceled from the intermediate care facility program, or

b. When a facility continues to include as an item of cost an item or items which had in a prior audit been removed by an adjustment in the total audited costs, the auditor shall recommend to the department that the per diem be reduced to 75 percent of the current payment rate for the ensuing fiscal period. The department may, after considering the seriousness of the exception, make the reduction.

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

a. Field auditors of the department of inspections and appeals or representatives of Health and Human Services, upon proper identification, shall have the right to audit billings to the department and receipts of client participation, to ensure that the facility is not receiving payment in excess of the contractual agreement and that all other aspects of the contractual agreement are being followed, as deemed necessary.

b. Field auditors of the department of inspections and appeals or representatives of Health and Human Services, upon proper identification, shall have the right to audit records of the facility to determine proper handling of patient funds in compliance with subrule 82.9(3).

c. The auditor shall recommend and the department shall request repayment by the facility to either the department or the resident(s) involved, such sums inappropriately billed to the department or collected from the resident.

d. The facility shall have 60 days to review the audit and repay the requested funds or present supporting documentation which would indicate that the requested refund amount, or part thereof, is not justified.

e. When the facility fails to comply with paragraph “d” the requested refunds may be withheld from future payments to the facility. The withholding shall not be more than 25 percent of the average of the last six monthly payments to the facility. The withholding shall continue until the entire requested refund amount is recovered. If in the event the audit results indicate significant problems, the audit results may be referred to the attorney general’s office for whatever action may be deemed appropriate.

f. When exceptions are taken during the scope of an audit which are similar in nature to the exceptions taken in a prior audit, the auditor shall recommend and the department may, after considering the seriousness of the exceptions, reduce payment to the facility to 75 percent of the current payment rate.

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

441—82.18(249A) Out-of-state facilities. Payment will be made for care in out-of-state intermediate care facilities for the mentally retarded. Out-of-state facilities shall abide by the same policies as in-state facilities with the following exceptions:

82.18(1) Out-of-state providers will be reimbursed at the same intermediate care facility rate they are receiving for their state of residence.

82.18(2) Out-of-state facilities shall not submit financial and statistical reports as required in rule 441—81.6(249A).

82.18(3) Payment for periods when residents are absent for visitation or hospitalization will be made to out-of-state facilities at 80 percent of the rate paid to the facility by the Iowa Medicaid program. Out-of-state facilities with 15 or fewer beds shall be reimbursed at 95 percent of the rate paid to the facility by the Iowa Medicaid program.

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

441—82.19(249A) State-funded personal needs supplement. A Medicaid member living in an intermediate care facility for persons with mental retardation who has countable income for purposes of rule 441—75.16(249A) of less than \$50 per month shall receive a state-funded payment from the department for the difference between that countable income and \$50 if the legislature has appropriated funding specifically for this purpose. This payment shall not be considered a benefit under Title XIX of the Social Security Act.

This rule is intended to implement Iowa Code Supplement section 249A.30A.

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◇ 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 medical institutions. 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.

DIVISION I—HCBS ILL AND HANDICAPPED 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 ill and handicapped 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.

“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.

“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 the mentally retarded 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.

“*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.

“*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.

441—83.2(249A) Eligibility. To be eligible for ill and handicapped 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 ill and handicapped 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 the mentally retarded. The IME medical services unit shall be responsible for approval of the certification of the level of care.

Ill and handicapped waiver services will not be provided when the individual is an inpatient in a medical institution.

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.

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 paragraphs 441—75.5(2) “b” and 441—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 consumer shall have a service plan approved by the department which is developed by the service worker identified by the county of residence. This service plan must be completed prior to services provision and annually thereafter.

The service worker shall establish the interdisciplinary team for the 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 using the following criteria:

(1) This service plan shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form 470-0659. Form 470-0659 is completed annually, or more frequently upon request or when there are changes in the consumer's condition. The service worker shall have a face-to-face visit with the consumer at least annually.

(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 service worker 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 consumer's service needs through nonwaiver Medicaid services.

b. Except as provided below, the total monthly cost of the ill and handicapped waiver services shall not exceed the established aggregate monthly cost for level of care as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>	<u>ICF/MR</u>
\$2,631	\$904	\$3,203

(1) For consumers eligible for SSI who remain eligible for ill and handicapped waiver services until the age of 25 because they are receiving ill and handicapped waiver services upon reaching the age of 21, these amounts shall be increased by the cost of services for which the consumer would be eligible under 441—subrule 78.9(10) if still under 21 years of age.

(2) If more than \$505 is paid for home and vehicle modification services, the service worker shall encumber up to \$505 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

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. 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.

441—83.3(249A) Application.

83.3(1) *Application for HCBS ill and handicapped 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 ill and handicapped waiver shall be subject to the number of consumers to be served as set forth in the federally approved HCBS ill and handicapped waiver. The number of consumers 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 consumers 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 contact the bureau of long-term care for all applicants for the waiver to determine if a payment slot is available.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau 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 recipients, the county department office shall contact the bureau by the end of the fifth working day after receipt of either Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, with the choice of HCBS waiver indicated by signature of the consumer or a written request signed and dated by the consumer.

(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 bureau of long-term care shall enter persons on a waiting list according to the following:

(1) Consumers 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 date-stamped in the county department office or upon the county department office's receipt of disability determination, whichever is later.

(2) Consumers 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 date-stamped in the county department office.

(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 ill and handicapped 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 completed assessment, Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, has been submitted to the IME medical services unit.
- (5) The application is pending because the assessment, Form 470-0659, or the service plan 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, Form 470-0659, or service plan, the application shall be denied. The consumer shall have the right to appeal.

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

c. A consumer must be given the choice between HCBS ill and handicapped waiver services and institutional care. The income maintenance or service worker shall have the consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care complete and sign Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, indicating the consumer's choice of home- and community-based services or institutional care.

d. Waiver services provided prior to approval of eligibility for the waiver cannot be paid.

e. A consumer may be enrolled in only one waiver program at a time. Costs for waiver services are not reimbursable while the consumer 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 and the case plan are completed, but shall not be earlier than the first of the month following the date of application.

b. The effective date of eligibility for the ill and handicapped waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom paragraphs "a" and "c" of this subrule do not apply is the date on which the income eligibility and level of care determinations and the case plan are completed.

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

d. Eligibility continues until the consumer has been in a medical institution for 30 consecutive days for other than respite care. Consumers who are inpatients in a medical institution for 30 or more consecutive days for other than respite care shall be terminated from ill and handicapped 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.

83.3(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.

441—83.4(249A) Financial participation. Persons must contribute their predetermined financial participation to the cost of ill and handicapped 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 for ill and handicapped waiver services, Medicaid shall make no payments to ill and handicapped 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.

441—83.5(249A) Redetermination. A complete redetermination of eligibility for the ill and handicapped 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 case plan meeting the requirements listed in rule 441—83.7(249A).

441—83.6(249A) Allowable services. Services allowable under the ill and handicapped 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).

441—83.7(249A) Service plan. A service plan shall be prepared for ill and handicapped 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.

83.7(1) The service plan shall include the frequency of the ill and handicapped waiver services and the types of providers who will deliver the services.

83.7(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.

83.7(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 consumer in an emergency.

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 130.5(2) "a," "b," "c," "g," or "h" apply.
- b. The costs of the ill and handicapped waiver service for the person exceed the aggregate monthly costs established in 83.2(2) "b."

c. The client receives care in a hospital, nursing facility, or intermediate care facility for the mentally retarded for 30 days in any one stay for purposes other than respite care.

d. The client receives ill and handicapped 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.

83.8(3) Reduction of services shall apply as in subrule 130.5(3), paragraphs "a" and "b."

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.

"Medical institution" means a nursing facility which has been approved as a Medicaid vendor.

"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.

"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.

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. The IME medical services unit shall be responsible for approval of the certification of the level of care. Elderly waiver services will not be provided when the person is an inpatient in a medical institution.
- 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 441—subrule 77.33(21). 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 are limited as follows:

<u>Skilled level of care</u>	<u>Nursing level of care</u>
\$2,631	\$1,300

(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]

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 consumer, guardian, or attorney in fact under a durable power of attorney for health care shall sign the service plan indicating the consumer's choice of caregiver.

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 cannot precede the date the case manager signs the case plan.

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.

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).

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). 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—83.30(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.

“*Medical institution*” means a nursing facility or hospital which has been approved as a Medicaid vendor.

“*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.

“*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.

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. The IME medical services unit shall be responsible for approval of the certification of the level of care. 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 county social worker shall perform an assessment of the person’s need for waiver services and determine the availability and appropriateness of services. This assessment shall be based, in part, on information in the completed Home- and Community-Based Services Assessment or Reassessment, Form 470-0659. Form 470-0659 shall be completed annually.
- 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 \$1,751.

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 or pending although the completed assessment, Form 470-0659, 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. A consumer must be given the choice between HCBS AIDS/HIV waiver services and institutional care. The income maintenance or service worker shall have the consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care complete and sign Form 470-0659, Home- and Community-Based Services Assessment or Reassessment, indicating the consumer's choice of home- and community-based services or institutional care.

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 and the service plan are completed.

b. The effective date of eligibility for the AIDS/HIV waiver for persons who qualify for Medicaid due to eligibility for the waiver services and to whom 441—subrule 75.1(7) and rule 441—75.5(249A) do not apply is the date on which income and resource eligibility and level of care determinations and the service plan are completed.

c. 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 and the service plan 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.

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).

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). 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, an appeal may be filed with the department.

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 mental retardation 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.

“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, 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 mental retardation 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 mental retardation professional (QMRP) 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.

“Intermediate care facility for the mentally retarded (ICF/MR)” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of persons who are mentally retarded 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.

“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.

“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 the mentally retarded, 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.

“Mental retardation” means a diagnosis of mental retardation under this division which shall be made only when the onset of the person’s condition was prior to the age of 18 years 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 psychologist or psychiatrist who is professionally trained to administer the tests required to assess intellectual functioning and to evaluate a person’s adaptive skills. A diagnosis of mental retardation shall be made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

“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 mental retardation professional” means a person who has at least one year of experience working directly with persons with mental retardation 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 mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of a mentally retarded person and requires treatment or services similar to those required for a mentally retarded person.

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.

"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]

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 mental retardation or, for residential-based supported community living services only, be a person with a related condition 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 mental retardation	Recertification for persons with a diagnosis of mild or unspecified mental retardation
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A)	After the initial psychological evaluation, substantiate a diagnosis of mental retardation or, for residential-based supported community living services, a diagnosis of a related condition 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 mental retardation or, for residential-based supported community living services, a diagnosis of a related condition as defined in rule 441—83.60(249A) every three years and when a significant change occurs
18 through 21 years	<ul style="list-style-type: none"> • Psychological documentation substantiating diagnosis of mental retardation within three years before the application date, or • Diagnosis of mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation 	Psychological documentation substantiating a diagnosis of mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation every five years and whenever a significant change occurs
22 years and above	Diagnosis made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation if the last testing date was (1) more than five years ago for an applicant with a diagnosis of mild or unspecified mental retardation, or (2) more than ten years ago for an applicant with a diagnosis of moderate, severe or profound mental retardation	Psychological documentation substantiating a diagnosis of mental retardation made since the member reached 18 years of age	Psychological documentation substantiating a diagnosis of mental retardation 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/MR. The IME medical services unit shall be responsible for annual approval of the certification of the level of care based on the data collected by the case manager and interdisciplinary team on a tool designated by the department.

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

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 supported employment services:

(1) Be at least age 16.

(2) Rescinded IAB 7/1/98, effective 7/1/98.

(3) Not be eligible for supported employment service funding under Public Law 94-142 or for the Rehabilitation Act of 1973.

(4) Not reside in a medical institution.

h. Choose HCBS intellectual disability waiver services rather than ICF MR services.

i. 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.

j. Be assigned an HCBS intellectual disability payment slot pursuant to subrule 83.61(4).

k. 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/MR;

2. Be at risk of ICF/MR 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.

l. For day habilitation, be 16 years of age or older.

m. 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 or services of a department-qualified mental retardation professional (QMRP) shall have the applicable coordinating staff and other interdisciplinary team members complete Form 470-4694, Case Management Comprehensive Assessment, and identify the applicant's needs and desires as well as the availability and appropriateness of the services.

b. Applicants not receiving services as set forth in paragraph 83.61(2)“a” shall have a department service worker or case manager:

(1) Complete Form 470-4694, Case Management Comprehensive 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 service worker, department QMRP, or Medicaid case manager shall complete Form 470-4694, Case Management Comprehensive Assessment, for the initial level of care determination within 30 days from the date of the HCBS application unless the worker can document difficulty in locating information necessary for completion of Form 470-4694 or other circumstances beyond the worker's control.

g. At initial enrollment, the service worker, department QIDP, case manager or Medicaid 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 assessments:

(1) The assessment shall be based, in part, on information on the completed Case Management Comprehensive Assessment, Form 470-4694.

(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]

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/MR care. The case manager or worker shall have the consumer or legal representative complete and sign Form 470-4694, Case Management Comprehensive Assessment, indicating 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]

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 eligibility for HCBS intellectual disability waiver services 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—83.61(249A).

[ARC 9650B, IAB 8/10/11, effective 10/1/11]

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]

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). The applicant or consumer 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 consumer may file an appeal with the department.

[ARC 0191C, IAB 7/11/12, effective 7/1/12]

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.
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.
“*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.

“*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.

“*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 the mentally retarded, 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 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; 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.

“*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.

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 aged 1 month to 64 years.
- 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 the mentally retarded (ICF/MR), skilled nursing, or ICF level of care.
- 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.

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 shall not exceed \$2,812 per month. If more than \$505 is paid for home and vehicle modification services, the service worker shall encumber up to \$505 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

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 contact the bureau of long-term care to determine if a payment slot is available for all new applications for the HCBS BI waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau by the end of the second working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application.

(2) For current Medicaid recipients, the county department office shall contact the bureau by the end of the second working day after receipt of either Form 470-3349, Brain Injury Functional Assessment, with the choice of the HCBS waiver indicated by the consumer's signature, or a written request signed and dated by the consumer.

b. On the third day after the receipt of the completed Form 470-2927 or 470-2927(S), if no payment slot is available, the bureau of long-term care shall enter the consumer on a waiting list according to the following:

(1) Consumers 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 date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added to the waiting list on the basis of the date the consumer requests HCBS BI program services as documented by the date of the consumer's signature on Form 470-2927 or 470-2927(S). In the event that more than one application is received at one time, consumers shall be entered on the waiting list on the basis of 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.

[ARC 0191C, IAB 7/11/12, effective 7/1/12]

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. A consumer shall be given the choice between waiver services and institutional care. The consumer or legal representative shall complete and sign Form 470-3349, Brain Injury Functional Assessment, indicating the consumer's choice of caregiver. 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 appropriate case manager for the consumer's county of residence 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.

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 consumer annually and certify the consumer'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 Brain Injury Waiver Functional Assessment, Form 470-3283, and supporting documentation as needed.

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]

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). The applicant or consumer 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 consumer may file an appeal with the department.

[ARC 0191C, IAB 7/11/12, effective 7/1/12]

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.

“Medical institution” means a nursing facility, a skilled nursing facility, intermediate care facility for the mentally retarded, or hospital which has been approved as a Medicaid vendor.

“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.

“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.

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. 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. After notice of an adverse decision by the IME medical services unit, the Medicaid applicant or recipient or the applicant's or recipient's representative may request reconsideration by the IME medical services unit pursuant to subrule 83.109(2). On initial and reconsideration decisions, 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). Adverse decisions by the IME medical services unit on reconsiderations may be appealed to the department pursuant to 441—Chapter 7 and rule 441—83.109(249A).
- 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 consumer shall have a service plan which is developed by the consumer and a department service worker. This must be completed and approved prior to service provision and at least annually thereafter.

The service worker shall identify the need for service based on the needs of the consumer as well as the availability and appropriateness of services.

- b. The total cost of physical disability waiver services shall not exceed \$659 per month. If more than \$505 is paid for home and vehicle modification services, the service worker shall encumber up to \$505 per month within the monthly dollar cap allowed for the consumer until the total amount of the modification is reached within a 12-month period.

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 contact the bureau of long-term care for all cases to determine if a slot is available for all new applications for the HCBS physical disability waiver program.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau by the end of the second working day after receipt of a completed Form 470-2927 or 470-2927(S), Health Services Application, submitted on or after April 1, 1999.

(2) For current Medicaid recipients, the county department office shall contact the bureau by the end of the second working day after receipt of Form 470-3502, Physical Disability Waiver Assessment Tool, with the choice of HCBS waiver indicated by the signature of the consumer or a written request signed and dated by the consumer.

b. On the third day after the receipt of the completed Form 470-2927 or 470-2927(S), Health Services Application, if no slot is available, the bureau of long-term care shall enter consumers on the HCBS physical disabilities waiver waiting list according to the following:

(1) Consumers 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 submitted on or after April 1, 1999, and date-stamped in the county department office. Consumers currently eligible for Medicaid shall be added on the basis of the date the consumer requests HCBS physical disability program services as documented by the date of the consumer's signature on Form 470-2927 or 470-2927(S). In the event that more than one application is received on the same day, consumers 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]

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. The discharge planner shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the IME medical services unit. 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. The applicant, the applicant's parent, the applicant's legal guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall complete Form 470-3502, Physical Disability Waiver Assessment Tool, and submit it to the IME medical services unit. 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 Form 470-3502, Physical Disability Waiver Assessment Tool, indicating the applicant's choice of caregiver.

e. The applicant, the applicant's parent or guardian, or the applicant's attorney in fact under a durable power of attorney for health care shall cooperate with the service worker in the development of the service plan, which must be approved by the department service worker 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 rule 441—83.102(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—83.102(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—83.102(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 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.

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 and the DHS service worker prior to services beginning and payment being made to the provider. The plan shall be reviewed by the consumer and the service worker annually, and the current version approved by the service worker.

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 shall review the consumer's need for continued care annually and recertify the consumer's need for long-term care services, pursuant to the standards and subject to the reconsideration and appeal processes at paragraph 83.102(1) "h" and rule 441—83.109(249A), based on the completed Form 470-3502, Physical Disability Waiver Assessment Tool, and supporting documentation as needed. Form 470-3502 is completed by the service worker at the time of recertification.

83.107(3) Case file. Rescinded IAB 8/7/02, effective 10/1/02.

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. After notice of an adverse decision by the IME medical services unit on the level of care requirement pursuant to paragraph 83.102(1)“*h*,” the Medicaid applicant or recipient or the applicant’s or recipient’s representative may request reconsideration by the IME medical services unit by sending a letter requesting a review to the IME medical services unit not more than 60 days after the date of the notice of adverse decision. Adverse decisions by the IME medical services unit on reconsiderations may be appealed to the department pursuant to 441—Chapter 7.

a. If a timely request for reconsideration of an initial denial determination is made, the IME medical services unit shall complete the reconsideration determination and send written notice including appeal rights to the Medicaid applicant or recipient and the applicant’s or recipient’s representative within ten working days after the IME medical services unit receives the request for reconsideration and a copy of the medical record.

b. If a copy of the medical record is not submitted with the reconsideration request, the IME medical services unit will request a copy from the facility within two working days.

c. The notice to parties. Written notice of the IME medical services unit’s reconsidered determination will contain the following:

- (1) The basis for the reconsidered determination.
- (2) A detailed rationale for the reconsidered determination.
- (3) A statement explaining the Medicaid payment consequences of the reconsidered determination.
- (4) A statement informing the parties of their appeal rights, including the information that must be included in the request for hearing, the locations for submitting a request for an administrative hearing, and the time period for filing a request.

d. If the request for reconsideration is mailed or delivered to the IME medical services unit within ten days of the date of the initial determination, any medical assistance payments previously approved will not be terminated until the decision on reconsideration. If the initial decision is upheld on reconsideration, medical assistance benefits continued pursuant to this rule will be treated as an overpayment to be paid back to the department.

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.

“*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.

“*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).

“*Medical institution*” means a nursing facility, an intermediate care facility for the mentally retarded, 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.

“*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 Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV-TR), 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 developmental disorders, substance-related disorders, or conditions or problems classified in DSM-IV-TR as “other conditions that may be a focus of clinical attention” (V codes), 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.

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 consumer 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 shall certify the consumer's level of care annually based on Form 470-4211, Children's Mental Health Waiver Assessment.

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 consumer must choose HCBS children's mental health waiver services over institutional care, as indicated by the signature of the consumer's parent or legal guardian on Form 470-4211, Children's Mental Health Waiver 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 targeted case management services or be identified to receive targeted case management services immediately following program enrollment.

b. The total cost of children's mental health waiver services needed to meet the consumer's needs may not exceed \$1,873 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]

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;
- (2) Form 470-4211, Children's Mental Health Waiver Assessment, with HCBS waiver choice indicated by signature of a Medicaid member's parent or legal guardian; or
- (3) 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 consumers 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 submitted and date-stamped in the local office;

(2) The names of Medicaid members shall be added to the waiting list on the date Form 470-4211, Children's Mental Health Waiver Assessment, or a written request as specified in 83.123(2) "a"(3) is date-stamped in the local office.

(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 or the service plan has not been completed. When a determination is not completed 90 days after the date of application due to the lack of a service plan, the application shall be denied.

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

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;

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

c. The service plan has been completed.

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

- a. Continuing eligibility factors as specified in rule 441—83.122(249A).
- b. The existence of a current service plan meeting the requirements listed in rule 441—83.125(249A).

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.

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 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 Form 470-4211, Children's Mental Health Waiver Assessment.

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.

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.

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."

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). An applicant or consumer may obtain a review of the IME medical services unit's level-of-care determination by sending a letter requesting a review to the IME Medical Services Unit, P.O. Box 36478, Des Moines, Iowa 50315. If dissatisfied with the IME medical services unit's review decision, the applicant or consumer may file an appeal with the department in accordance with 441—Chapter 7.

These rules are intended to implement Iowa Code section 249A.4 and 2005 Iowa Acts, chapter 167, section 13, and chapter 117, section 3.

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CHAPTER 88
MANAGED HEALTH CARE PROVIDERS
[Prior to 2/11/87, Human Services[498]]

PREAMBLE

This chapter contains rules governing the delivery of managed health care under the Medicaid program. These rules make provision for the following managed health care options: health maintenance organizations (HMOs), prepaid health plans (PHPs), patient management, known as Medicaid Patient Access to Service System (MediPASS), the managed care plan for the delivery of mental health and substance abuse services (Iowa Plan for Behavioral Health), and programs of all-inclusive care for the elderly (PACE). The rules cover eligibility of a provider to participate, reimbursement methodologies, record-keeping requirements, grievance procedures, and member enrollment and disenrollment procedures. Services covered or requiring authorization and member access to services are specified.

DIVISION I
HEALTH MAINTENANCE ORGANIZATION

441—88.1(249A) Definitions.

“Capitation rate” shall mean the fee the department pays monthly to an HMO for each enrolled recipient for the provision of covered medical and health services whether or not the enrolled recipient received services during the month for which the fee is intended.

“Contract” shall mean a contract between the department and an HMO for the provision of medical and health services to Medicaid recipients in which the HMO assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

“Covered services” shall mean all or a part of those medical and health services set forth in 441—Chapter 78 and covered in the contract between the department and an HMO.

“Department” shall mean the Iowa department of human services.

“Emergency care” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“Emergent medical condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

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

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient’s medical condition, including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

“Enrolled recipient” shall mean a Medicaid recipient who is eligible for HMO enrollment as defined at subrule 88.2(4) and has been enrolled with an HMO as defined at subrule 88.3(2) or 88.3(7).

“Enrollment area” shall mean the county or counties or region or regions in which an HMO is licensed to operate by the state of Iowa and in which service capability exists as defined by the department and set forth in the contract. An enrollment area shall not be less than an entire county but may be less than a region. Regions shall be established by the department and outlined in the contract with the HMO.

“Extended-participation program” shall mean a mandatory six-month enrollment period with a managed care entity.

“Federally qualified HMO” shall mean an HMO qualified under Section 1315(a) of the Public Health Service Act as determined by the U.S. Public Health Service.

“*Grievance*” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the HMO staff member receiving the complaint or any complaint received in writing.

“*Health maintenance organization (HMO)*” shall mean a public or private organization which is licensed as an HMO under commerce department rules 191—Chapter 40.

“*Managed care entity*” shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

“*Managed health care*” shall mean any one of the alternative deliveries of regular fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“*Managed health care review committee*” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“*Mandatory enrollment*” shall mean mandatory participation in managed health care as specified in subrule 88.3(3).

“*Mandatory project county*” shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

“*Noncovered services*” shall mean services covered under Medicaid which are not included in the HMO’s contract with the department. Payment for these services will be made under regular Medicaid procedures.

“*Participating providers*” shall mean the providers of covered medical and health services who subcontract with or who are employed by an HMO.

“*Recipient*” shall mean any person determined by the department to be eligible for Medicaid and for HMO enrollment. See subrule 88.2(4) for a list of Medicaid eligibles who are not eligible for HMO enrollment.

“*Region*” shall mean an area consisting of two or more contiguous counties, as established by the department and specified in contracts with health maintenance organizations.

“*Routine care*” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“*Urgent care*” shall mean those medical services rendered for an urgent medical condition or protection of the public health.

“*Urgent medical condition*” shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

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

441—88.2(249A) Participation.

88.2(1) Contracts with HMOs. The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with an HMO licensed under the provisions of commerce department rules 191—Chapter 40.

- a. The department must determine that the HMO meets the following additional requirements:

(1) It shall make the services it provides to its Medicaid enrollees at least as accessible to them (in terms of timeliness, duration and scope) as those services are accessible to nonenrolled Medicaid recipients in the area served by the HMO.

(2) It shall provide satisfaction to the department against the risk of insolvency and assure that Medicaid recipients shall not be responsible for its debts if it does become insolvent. Compliance shall exist with commerce department rules regarding deposit requirements at 191—40.12(514B) and reporting requirements at 191—40.14(514B).

(3) For any contract executed or extended to be in effect on or after July 1, 2002, an HMO must have accreditation by the National Committee on Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Be renewable by mutual consent for a period of up to three years.

(3) List the services covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationship.

(8) Be made with the licensee by the department.

(9) Specify the enrollment area which shall be at least a county and effective July 1, 1998, a region of two or more contiguous counties.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the HMO, specifying the number of days the HMO has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The HMO may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.2(2) *Method of selection of HMO.* In those counties served by a single HMO, the department shall attempt to negotiate a contract. In those counties served by two or more HMOs, the department shall initiate communication and attempt to negotiate as many contracts as are cost-effective and administratively feasible. The department reserves the right to contract with more than one HMO serving any enrollment area.

a. *Request for proposal.* Rescinded IAB 11/10/93, effective 11/1/93.

b. *Minimum contract requirements.* Rescinded IAB 11/10/93, effective 11/1/93.

88.2(3) *Termination of contract.* The department and an HMO may by mutual consent terminate a contract by either party giving 60 days' written notice to the other party. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based on factors including, but not limited to, the following:

a. The HMO's delivery system does not ensure Medicaid recipients adequate access to medical services.

b. The HMO's delivery system does not ensure the availability of all services covered under the contract.

c. There are not proper assurances of financial solvency on the part of the HMO.

d. There is not substantial compliance with all provisions of the contract.

e. The HMO has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.2(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting HMO except for the following:

a. Recipients who are medically needy as defined at 441—subrule 75.1(35).

- b. Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
- c. Recipients who are supplemental security income-related case members.
- d. Rescinded IAB 10/3/01, effective 12/1/01.
- e. Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
- f. Recipients who are foster care and subsidized adoption-related case members.
- g. Recipients who are Medicare beneficiaries.
- h. Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
- i. Recipients who are Native American Indians or Alaskan natives.
- j. Recipients who are receiving services from a Title V provider.

441—88.3(249A) Enrollment.

88.3(1) *Enrollment area.* Counties in an HMO enrollment area shall be designated as either voluntary or mandatory. In voluntary counties enrollment is not required but eligible recipients may choose to join the HMO. See subrule 88.3(2) for information about voluntary enrollment. In mandatory counties enrollment is required for eligible recipients. See subrule 88.3(3) for information about mandatory enrollment.

88.3(2) *Voluntary enrollment.* When only one HMO in any county has a contract with the department, and the county is not a mandatory project county for Medicaid Patient Management (MediPASS) under subrule 88.43(1), enrollment by Medicaid recipients in the HMO is voluntary. The state encourages recipients to enroll in an HMO. Applicants and recipients eligible for HMO enrollment as set forth in subrule 88.2(4) are offered the option of HMO enrollment. Persons who enroll with the HMO shall have the right to request disenrollment at any time as defined at subrule 88.4(3).

Applicants or recipients can designate their choices on a form designated by the managed health care contractor or in writing to or with a verbal request to the Medicaid managed health care contractor. The form shall be available through the county office, provider offices, the HMO office, the managed health care contractor, or other locations at the department's discretion. If the HMO (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the HMO in the order in which they enroll without restrictions.

Recipients who choose not to enroll in an HMO shall be covered under regular Medicaid.

88.3(3) *Mandatory enrollment.* Participation in managed health care, if available, is required as specified in this subrule for covered eligibles who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.3(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the designated managed health care choice form or written or verbal request except as defined at 88.4(4) "b." The recipients shall be entitled to regular Medicaid until the effective date of HMO enrollment which shall always be the first day of the month. The effective date shall be earlier than the second subsequent month where computer cutoff allows.

88.3(5) *Identification card.* The HMO may issue an appropriate identification card to the enrollee or request the department to do it on its behalf. The identification card shall be issued so the recipient receives it prior to the effective date of enrollment.

88.3(6) *Limitations on enrollment.* Contracting managed care entities may specify in a contract a limit to the number of recipients who can be assigned under subrule 88.3(7). If a limit is specified, the contracting entity must still provide services to all enrolled recipients who voluntarily select enrollment

in that option. If a specified limitation is reached, the remaining assignment needs in that county shall be met by the other managed care entities who are contracting with the department in that county.

88.3(7) Enrollment procedures. In mandatory enrollment counties, recipients shall be required to choose their managed care entity. When no choice is made by the recipient, the recipient shall be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. If not, the household shall be assigned to another physician. MediPASS patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.4(2) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed care entity assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or from a voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

c. Selection of a managed health care provider. A list of health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers, the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request may be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.4(2) dealing with effective date.

e. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen entity for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."

- (2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) “b.”
- (3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

f. Enrollment cycle. Prior to the end of any EPP period, recipients shall be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

441—88.4(249A) Disenrollment.

88.4(1) *Disenrollment request.* Rescinded IAB 5/6/98, effective 7/1/98.

88.4(2) *Effective date.* Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the HMO and the HMO will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.4(3) *Disenrollment process.* The recipient may complete the form designated by the managed health care contractor which can be obtained through the locations described in subrule 88.3(2). The recipient may also make a verbal or written request through the managed health care contractor. If the HMO or any other entity described in subrule 88.3(2) receives a request to disenroll from the recipient, the request shall be forwarded to the Medicaid managed health care contractor office within three working days. If the recipient must show good cause for disenrollment or if the HMO is requesting disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or HMO disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. The HMO may request disenrollment of a recipient by showing good cause and completing Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three days.

a. Request for disenrollment by the recipient. The enrolled recipient may request disenrollment by completing a choice form designated by the managed health care contractor, in writing or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from timely notice date. After this time period, a recipient may be disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality or inadequately provided. In a mandatory county, a disenrollment request must be accompanied by a choice for another managed health care provider.

b. Request for disenrollment by the HMO. With prior approval of the DHS/HMO Review Committee a recipient may be disenrolled when:

(1) There is evidence of fraud or forgery in the use of HMO services or in the application for HMO coverage.

(2) There is evidence of unauthorized use of the HMO identification card.

(3) Upon documentation that the HMO has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient. Examples include, but are not limited to, repeated failure to follow a prescribed treatment plan, disruptive or abusive behavior with office or clinic staff, documented pattern of missed appointments or “drop-in” requests for service without making appointments.

88.4(4) *Disenrollments by the department.* Disenrollments will occur when:

a. The contract between the department and the HMO is terminated.

b. The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the HMO will also be reinstated.

c. The recipient permanently moves outside the HMO’s enrollment area.

d. The recipient transfers to an eligibility group excluded from HMO enrollment. See definition of recipient in rule 441—88.1(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

f. The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in rule 441—76.9(249A), would be more cost-effective for the department.

88.4(5) *No disenrollment for health reasons.* No recipient will be disenrolled from an HMO because of an adverse change in health status.

441—88.5(249A) Covered services.

88.5(1) *Amount, duration, and scope of services.* Except as provided for in the contract, HMOs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

a. The recipient shall be issued Form 470-1911, Medical Assistance Eligibility Card, and information about those services not covered by the HMO.

b. To the maximum extent possible, the HMO shall make enrolled recipients aware of alternate providers for services not covered by the HMO.

88.5(2) *Required services.*

a. The HMO shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Early periodic screening, diagnosis and treatment for individuals under the age of 21.
- (7) Laboratory and X-ray services.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.
- (10) Optometric and ophthalmology services.
- (11) Clinic services.
- (12) Ambulance services.
- (13) Rescinded IAB 11/5/97, effective 1/1/98.
- (14) Other practitioner services (e.g., speech therapy, audiology, physical therapy, and occupational therapy).
- (15) Rehabilitation agencies.

b. HMOs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and maternal and child health centers funded by Title V moneys. The attempt to contract by the HMO is expected to be a reasonable and good faith effort. The determination of whether or not a good faith effort was made shall be completed by the department.

88.5(3) *Excluded services.* Unless specifically included in the contract, HMOs will not be required to cover:

- a.* Long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state hospital schools, or intermediate care facilities for the mentally retarded).
- b.* Inpatient psychiatric care provided at state-administered mental health institutes.
- c.* Services provided by the area education agencies.
- d.* Services provided at psychiatric medical institutions for children.
- e.* Dental services.
- f.* Hospice services.
- g.* Mental health services as defined in rule 441—88.65(249A).
- h.* Rescinded IAB 8/1/07, effective 9/5/07.
- i.* Psychiatric services.
- j.* Infant and toddler program services.
- k.* Local education agency services.

Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the HMO. The department will continue to reimburse as it currently does for this service.

88.5(4) Restrictions and limitations. If the HMO covers a type of service which is also covered under Medicaid, the HMO shall offer the same scope of procedures available under regular Medicaid as described in the provisions at 441—Chapter 78. The HMO may not impose limitations on days of service or length of stay not pertinent to regular Medicaid. The HMO may, however, require the use of certain providers, as defined in subrule 88.5(5); require preauthorization for services other than those meeting the definition of emergency, as defined in rule 441—88.1(249A); direct enrollees to the appropriate level of care for receipt of covered services; and deny payment if these enrollment requirements are not met by the enrollee. The HMO may at its discretion offer services to recipients beyond the scope of Medicaid as defined in 441—Chapter 78.

88.5(5) Recipient use of HMO services. A recipient enrolled in an HMO must use HMO providers of service, unless the HMO has authorized a referral to a provider outside the HMO for provision of a service or treatment plan. Payment shall be denied by the HMO on claims for services provided by non-HMO providers if the same service is covered by the HMO under its contract with the department except as provided in rule 441—88.6(249A), as allowed for by a referral to a non-HMO provider, or as an additional service permitted by subrule 88.5(4).

441—88.6(249A) Emergency and urgent care services.

88.6(1) Availability of services. The HMO shall ensure that emergency services are available on an emergency basis 24 hours a day, seven days a week, either through the HMO's own providers or through arrangements with other providers. In addition the HMO must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have arrangements with the HMO to provide services but were provided because they were needed immediately as defined at rule 441—88.1(249A) and in which cases the medical emergency does not permit a choice of provider.

88.6(2) HMO payment liability. HMO payment liability on account of injury or emergency illness is limited to emergency care as defined in rule 441—88.1(249A). If an ambulance is medically necessary to transport the recipient to follow-up treatment the HMO shall be financially liable. The HMO may require that follow-up treatment to an emergency be provided by HMO-participating providers.

If a recipient is injured or becomes ill and receives emergency services while temporarily outside the HMO's enrollment area, the HMO shall pay the facility or person who rendered the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.6(3) Notification and claim filing time spans. The HMO may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or file claims within those time limitations will not invalidate any claim if it can be shown not to have been reasonably possible to give such notice and that notice was in fact given as soon as was reasonably possible.

88.6(4) Provision of urgent care. If the recipient is assigned to a patient manager by the HMO, the patient manager shall arrange for urgent care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

441—88.7(249A) Access to service.

88.7(1) Choice of provider. Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the HMO providers participating in the Medicaid project.

88.7(2) Medical service delivery sites. Medical service delivery sites must have the following specific characteristics:

- a. Be located within 30 miles of and accessible from the personal residences of enrolled recipients.

- b. Have sufficient staff resources to adequately provide the medical services contracted for by the site including physicians with privileges at one or more participating acute care hospitals.
- c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.
- d. Meet the applicable standards for participating in the Medicaid program.
- e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.7(3) Adequate appointment system. The HMO shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

- a. Patients with urgent symptoms shall be seen within one day of contacting their HMO provider at an HMO medical service delivery site.
- b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.
- c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.
- d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.7(4) Adequate after hours call-in coverage. The HMO must have in effect the following arrangements which provide for adequate after hours call-in coverage.

- a. Twenty-four-hour-a-day phone coverage shall exist.
- b. If a physician does not respond to the initial telephone call there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided by the physician within 30 minutes.
- c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.7(5) Adequate referral system. The HMO must effect the following arrangements which provide for an adequate referral system:

- a. A network of referral sources for all services which are covered in the contract and not provided by the HMO directly.
- b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physician, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.
- c. A notation for hospitalized patients in the medical record indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.8(249A) Grievance procedures.

88.8(1) Written procedure. The HMO must have a written procedure by which enrolled recipients may express grievances, complaints, concerns, or recommendations, either individually or as a class and which:

- a. Is approved by the department prior to use.
- b. Acknowledges receipt of a grievance to the grievant.
- c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.
- d. Ensures the participation of persons with authority to require corrective action.
- e. Includes at least one level of appeal.
- f. Ensures the confidentiality of the grievant.
- g. Ensures issuance of a departmentally approved notice of decision for each adverse action and for each decision on requests for HMO reconsideration. These notices shall contain the enrollee's appeal rights with the department and shall contain an adequate explanation of the action taken and the reason for the decision.

88.8(2) *Written record.* All grievances, including informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be maintained and made available at the time of audit and must include progress notes and resolutions.

88.8(3) *Information concerning grievance procedures.* The HMO's written grievance procedure must be provided to each newly covered recipient not later than the effective date of coverage.

88.8(4) *Appeals to the department.* A recipient shall exhaust the established grievance procedure of the HMO before appealing the issue to the department under the provisions of 441—Chapter 7. The HMO appeal process shall not be more stringent in requirements and time frames than the department's appeal process. The HMO shall issue a written notice stating the outcome of all appeals.

88.8(5) *Periodic report to the department.* The HMO must make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.9(249A) Records and reports.

88.9(1) *Medical records system.* The HMO shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and shall file a letter with the commissioner of insurance as described in Iowa Code section 228.7. In addition the HMO must maintain a medical records system which:

- a. Identifies each medical record by state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.9(3).
- f. Maintains inactive medical records in a specific place.
- g. Permits effective professional review in medical audit processes.
- h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i. Meets state and federal reporting requirements applicable to HMOs.

88.9(2) *Content of individual medical record.* The HMO must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.9(3) *Confidentiality of records.* HMOs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or responsible party.
- b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities who are providing services to enrolled recipients under a subcontract with the HMO. This provision also applies to specialty providers who are retained by the HMO to provide services which are infrequently used, provide a support system service to the operation of the HMO, or are of an unusual nature. This provision is also intended to waive the need for written consent for department staff assisting in the administration of the program, reviewers from the peer review organization (PRO), monitoring authorities from the Centers for Medicare and Medicaid Services (CMS), the HMO itself, and other subcontractors which require information as described under paragraph "e" of this subrule.
- c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—88.6(249A).
- d. Written consent is required for the transmission of the medical record information of a former enrolled recipient to any physician not connected with the HMO.
- e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a "need to know" on the part of the practitioner or a facility requesting the information.
- f. Medical records maintained by subcontractors must meet the requirements of this rule.

88.9(4) *Reports to the department.* Each HMO shall submit reports to the department as follows:

- a. Annual audited financial statements no later than 120 days after the close of the HMO's fiscal year or other additional terms as specified by the contract.
- b. Periodic financial, utilization, and statistical reports as required by the department under the contract.
- c. Time-specific reports required by the contract which define activity for child health care, grievances, and other designated activities which may, at the department's discretion, vary among HMOs, depending on the services covered and other contractual differences.

88.9(5) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the HMO. The department or HHS may audit and inspect any records of an HMO, or the subcontractor of the HMO that pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee or HHS may request.

441—88.10(249A) Marketing.

88.10(1) General requirements. An HMO may not distribute directly or through any agent or independent contractor any marketing materials, without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

a. *Service market.* An HMO shall distribute any marketing materials to its entire service area or region.

b. *Prohibition of tie-ins.* An HMO, or any agency of the entity, may not seek to influence an individual's enrollment with the HMO in conjunction with the sale of any other insurance.

c. *Prohibiting marketing fraud.* Each HMO shall comply with the procedures and conditions the department prescribes in the contract in order to ensure that, before an individual is enrolled with the HMO, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

d. *Prohibition of "cold-call" marketing.* HMOs shall not, directly or indirectly, conduct door-to-door, telephonic, or other "cold-call" marketing of enrollment.

88.10(2) Marketing representatives. Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The HMO's marketing representatives must represent the HMO in an honest and straightforward manner. In its marketing presentations the HMO must include information which ensures that the marketing representative is not mistaken for a state or county employee.

88.10(3) Marketing presentations. The HMO may make marketing presentations in the local offices of the department or otherwise include the department in their marketing efforts at the discretion of the department.

88.10(4) Marketing materials. Written material must include a marketing brochure or a member handbook that fully explains the services available, how and when to obtain them, and special factors applicable to Medicaid recipients as specified in the contract.

441—88.11(249A) Patient education.

88.11(1) Health education procedures. The HMO will have written procedures for health education designed to prepare patients for participation in and reaction to specific medical procedures and to instruct patients in self-management of medical problems and in disease prevention. This service may be provided by any health practitioner or by any other person approved by the HMO.

88.11(2) Use of services. The HMO will have procedures in effect to orient covered persons in the use of all services provided. This includes but is not limited to written instructions regarding appropriate use of the referral system, grievance procedure, after hours call-in system, and provisions for emergency treatment.

88.11(3) Patient rights and responsibilities. The HMO shall have in effect a written statement of patient rights and responsibilities which is available to patients upon request and which is sent to all new enrolled recipients. The rights of the recipient to request disenrollment shall be included.

441—88.12(249A) Reimbursement.

88.12(1) *Capitation rate.* In consideration for all services rendered by an HMO under a contract with the department, the HMO will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

A portion of any increase in capitation payments may be reserved for an incentive payment to be paid based on the percentage of counties in a region included in an HMO's enrollment area. Incentive payments shall be made retroactively to the beginning of a state fiscal year if an HMO increases the percentage of counties in a region included in its enrollment area.

88.12(2) *Determination of rate.* The capitation rate is actuarially determined for the beginning of each new fiscal year using statistics and data about Medicaid fee-for-service expenses for HMO-covered services to a similar population during a base fiscal year. The capitation rate shall not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. HMOs electing to share risk with the department shall have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.12(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the HMO for risks assumed under the contract or any previous risk contract. Any savings realized by the HMO due to the expenditure for necessary health services by the enrolled population being less than the capitation rate paid by the department will be wholly retained by the HMO.

88.12(4) *Third-party liability.* If an enrolled recipient has health insurance coverage or a responsible party other than the Medicaid program available for payment of medical expenses it is the right and responsibility of the HMO to investigate these third-party resources and attempt to obtain payment. The HMO will retain all funds collected for third-party resources. A complete record of all income from these sources must be maintained and made available to the department on request.

441—88.13(249A) Quality assurance. The HMO shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.14(249A) Contracts with federally qualified health centers (FQHCs) and rural health clinics (RHCs). In the case of services provided pursuant to a contract between an FQHC or RHC and a managed care organization, the organization shall provide payment to the FQHC or RHC that is not less than the amount of payment that it would make for the services if furnished by a provider other than an FQHC or RHC. The payment from the managed care organization to the FQHC or RHC shall be supplemented by a direct payment from the department to the FQHC or RHC to provide reimbursement at 100 percent of reasonable cost as determined by Medicare cost reimbursement principles. FQHCs and RHCs shall be required to submit Form 470-3495, Managed Care Wraparound Payment Request Form, to the Iowa Medicaid enterprise provider audits and rate-setting unit to document Medicaid encounters and differences between payments by the managed care organization and 100 percent of reasonable cost as determined by Medicare cost reimbursement principles.

441—88.15 to 88.20 Reserved.

DIVISION II
PREPAID HEALTH PLANS

441—88.21(249A) Definitions.

"Capitation rate" shall mean the fee the department pays monthly to a PHP for each enrolled recipient for the provision of covered medical services whether or not the enrolled recipient received services during the month for which the fee is intended.

“*Contract*” shall mean a contract between the department and a PHP for the provision of medical services to enrolled Medicaid recipients for whom the PHP assumes a risk as defined in the contract. These contracts shall meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996.

“*Department*” shall mean the Iowa department of human services.

“*Emergency service*” shall mean those medical services rendered under unforeseen conditions which require hospitalization for the treatment of accidental injury and relief of acute pain, which, if not immediately diagnosed and treated, would result in risk of permanent danger to the patient’s health.

“*Enrollment area*” shall mean the county or counties which the PHP has capability to serve and is defined in the contract with the department. An enrollment area shall not be less than an entire county.

“*Grievance*” shall mean an incident, complaint, or concern which cannot be resolved in a manner satisfactory to enrolled recipients by the immediate response, verbal or otherwise, of the PHP staff member receiving the complaint or any complaint received in writing.

“*Managed health care*” shall mean any one of the alternative deliveries of regular, fee-for-service Medicaid such as defined in subrules dealing with health maintenance organizations (HMOs), or prepaid health plans (PHPs), or Medicaid Patient Access to Service System (MediPASS).

“*Managed health care review committee*” shall mean a committee composed of representatives from the department. The committee shall review and render a decision on all requests for disenrollment which are not automatically approvable.

“*Managed services*” shall mean all or part of those medical services set forth in 441—Chapter 78 and covered in the contract between the department and a PHP.

“*Nonmanaged services*” shall mean medical services covered under regular Medicaid, but which are not covered in the PHP’s contract with the department. Payment for nonmanaged services incurred by an enrolled recipient shall be made under regular Medicaid procedures.

“*Participating providers*” shall mean the providers of covered medical services who subcontract with or who are employed by the PHP.

“*Prepaid health plan (PHP)*” shall mean an entity defined in Section 1903(m)(2)(B)(iii) of the Social Security Act and considered to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3) as amended to March 31, 1991.

“*Recipient*” shall mean any person determined by the department to be eligible for Medicaid and for PHP enrollment. See subrule 88.22(4) for a list of Medicaid eligibles who are not eligible for PHP enrollment.

“*Routine care*” shall mean medical care which is not urgent or emergent in nature and can wait for a regularly scheduled physician appointment without risk of permanent damage to the patient’s life or health status. The condition requiring routine care is not likely to substantially worsen without immediate clinical intervention.

“*Urgent, nonemergency need*” shall mean the existence of conditions due to an illness or injury which are not life threatening but which require expeditious treatment because of the prospect of the condition worsening without immediate clinical intervention.

441—88.22(249A) Participation.

88.22(1) *Contracts with PHPs.* The department shall enter into contracts for the scope of services specified in 441—Chapter 78, or a part thereof, with a PHP which has verified to the department that the criteria set forth in the Social Security Act have been met. This verification shall be reviewed by Centers for Medicare and Medicaid Services (CMS) staff to ensure that the status of PHP is rightfully conferred.

a. The department shall also determine that the PHP meets the following additional requirements:

(1) The PHP shall make the services it provides to enrolled recipients at least as accessible (in terms of timeliness, duration, and scope) to them as those services are accessible to recipients in the enrollment area who are not enrolled.

(2) The PHP shall provide satisfaction to the department that insolvency is not likely to occur and that enrolled Medicaid recipients shall not be responsible for its debts if the PHP should become insolvent.

b. The contract shall meet the following minimum requirements. The contract shall:

- (1) Be in writing.
- (2) Be renewable by mutual consent for a period of up to three years.
- (3) List the services covered.
- (4) Describe information access and disclosure.
- (5) List conditions for nonrenewal, termination, suspension, and modification.
- (6) Specify the method and rate of reimbursement.
- (7) Provide for disclosure of ownership and subcontractor relationship.
- (8) Be made with the licensee by the department.

c. Any protests to the award of contracts shall be in writing and submitted to the director of the department. Prior to termination or suspension of a contract, the department shall send a notice to cure to the PHP, specifying the number of days the PHP has to correct the problems. Failure to correct the problems in the time given shall then result in termination or suspension. The PHP may appeal the decision of the department in writing to the director of the department or to the federal Department of Health and Human Services, Centers for Medicare and Medicaid Services, if the appeal documents state violations of federal law or regulation.

88.22(2) *Method of selection of PHP.* In counties served by a single prospective PHP, the department shall attempt to negotiate directly with the PHP. In counties where two or more prospective PHPs exist, the department shall initiate communication and attempt to negotiate as many contracts as are administratively feasible.

88.22(3) *Termination of contract.* Either party may, by mutual consent, terminate a contract. Either party may give 60 days written notice to the other party. The effective date of termination must be the first day of a month. The department may terminate or suspend a contract if the contract is determined by the department to be inconsistent with the overall goals and objectives of the Medicaid program. The determination shall be based upon, but not limited to, the following:

- a.* The PHP's delivery system does not ensure enrolled recipients adequate access to medical services.
- b.* The PHP's delivery system does not ensure the availability of all services covered under the contract.
- c.* There are not proper assurances of solvency on the part of the PHP.
- d.* There is not substantial compliance with all provisions of the contract.
- e.* The PHP has discriminated against persons eligible to be covered under the contract on the basis of age, race, sex, religion, national origin, creed, color, physical or mental disability, political belief, health status, or the need for health services.

88.22(4) *Recipients eligible to enroll.* Any Medicaid-eligible recipient is eligible to enroll in a contracting PHP except for the following:

- a.* Recipients who are medically needy as defined at 441—subrule 75.1(35).
- b.* Recipients over the age of 65 and under the age of 21 in psychiatric institutions as defined at 441—Chapter 85.
- c.* Recipients who are supplemental security income-related case members.
- d.* Rescinded IAB 10/3/01, effective 12/1/01.
- e.* Recipients whose eligibility is in the process of automatic redetermination as defined at rule 441—76.11(249A).
- f.* Recipients who are foster care and subsidized adoption-related case members.
- g.* Recipients who are Medicare beneficiaries.
- h.* Recipients who are pregnant women and who are deemed to be presumptively eligible as defined at 441—subrule 75.1(30).
- i.* Recipients who are Native American Indians or Alaskan natives.
- j.* Recipients who are receiving services from a Title V provider.

441—88.23(249A) Enrollment.

88.23(1) *Enrollment area.* Counties in a PHP enrollment area shall be designated as voluntary or mandatory. In voluntary counties, enrollment is not required but eligible recipients may choose to join the PHP. Recipients not excluded in rule 441—88.21(249A) may volunteer to enroll in the PHP. In mandatory counties, enrollment in managed health care is required for eligible recipients.

88.23(2) *Voluntary enrollment.* When only one managed health care option is providing service in a county, enrollment by recipients is voluntary. The department encourages recipients to enroll in a managed health care option. Applicants and recipients are offered the option of managed health care enrollment or regular Medicaid coverage. Applicants and recipients who do not choose one option or the other shall be assigned to a managed health care provider as defined in subrule 88.23(6). These persons shall have the right to request disenrollment at any time as defined in subrule 88.24(3).

Applicants or recipients may designate their choices of providers on a form designated by the managed health care contractor or in writing to or through a verbal request to the managed health care contractor. The form shall be available through the county office, the PHP office, provider offices, the managed health care contractor, or other locations at the department's discretion. If the PHP (or any entity listed above other than the managed health care contractor) receives the form, it shall be forwarded to the managed health care contractor within three working days.

Recipients shall be accepted by the PHP as they are enrolled by the department unless a maximum limit has been specified in the contract.

Recipients who choose not to enroll in a PHP shall be covered under regular Medicaid.

88.23(3) *Mandatory enrollment.* In a county where the department has a contract with more than one PHP, HMO, or other managed health care provider, the department shall require whenever it is administratively feasible that all eligible recipients enroll with a managed health care provider of their own choosing. Administrative feasibility is determined by whether the managed health care providers have the capacity to adequately serve all potential enrolled recipients. Recipients may enroll by completing the choice form designated by the managed health care contractor, in writing to or through verbal request to the managed health care offices. Recipients may also contact the managed health care contractor by the publicized toll-free telephone number for enrollment assistance.

88.23(4) *Effective date.* The effective date of enrollment shall be no later than the first day of the second month subsequent to the date on which the managed health care contractor receives the form designated by the managed health care contractor.

88.23(5) *Identification card.* The PHP may issue an appropriate identification card to the enrolled recipient or request the department to do so on its behalf. The identification card shall be issued so that the recipient receives it prior to the effective date of enrollment.

88.23(6) *Assignment methodology.* When no choice is made, the recipient shall be systematically assigned to, between, or among the contracting managed health care providers.

a. Notification. Recipients who are assigned to a managed health care provider shall receive notification of the assignment and the name of the provider in a timely fashion prior to the effective date of enrollment.

b. Limitations. Contracting providers may specify in the contract a limit to the number of recipients who can be assigned under this subrule. If a specified limitation is attained, the remaining assignment needs in that county shall be met by the other managed health care providers who are contracting with the department in that county.

c. Household member enrollment. Inasmuch as persons within a household are allowed to make individual decisions about choosing enrollment in managed health care, it is possible that a case may exist where some household members have made a choice and some have not (so that assignment is required). In these instances, a systematic search of household member choices regarding managed health care option shall be completed. Assignment of those who have made no choice shall be made whenever possible to the managed health care provider with whom the first household member is already enrolled.

d. Assigned recipients who desire another choice. Recipients who are assigned to a managed health care provider as described in this subrule shall have at least 30 days in which to request enrollment

in a different available managed health care plan. The change of plan is subject to provisions in subrules 88.23(4) and 88.24(2) dealing with effective date.

441—88.24(249A) Disenrollment.

88.24(1) *Disenrollment request.* An enrolled recipient may request disenrollment at any time. In voluntary counties, this request shall be approved and acted upon within ten days of receipt without requiring the recipient to demonstrate good cause. In mandatory counties as defined at subrule 88.23(3), the disenrollment shall not be acted upon by the health care contractor unless the request includes an alternate choice of managed health care.

88.24(2) *Effective date.* Disenrollment will be effective no later than the first day of the second calendar month after the month in which the department receives a request for disenrollment. The recipient will remain enrolled in the PHP and the PHP will be responsible for services covered under the contract until the effective date of disenrollment which will always be the first day of a month.

88.24(3) *Disenrollment process.* If the recipient is requesting disenrollment, the recipient shall complete the choice form designated by the managed health care contractor which can be obtained through the PHP, the county office, or the managed health care contractor. If the PHP receives a request from the recipient, the PHP shall forward the form to the managed health care contractor within three working days. If the recipient must show good cause for disenrollment, the determination as to whether disenrollment shall occur shall be made by the managed health care review committee within 30 days. If the recipient or the PHP disagrees with the decision of the review committee, an appeal may be filed under the provisions of 441—Chapter 7. If the PHP is requesting disenrollment, the PHP shall complete Form 470-2169, Managed Health Care Provider Request for Disenrollment. If the county office receives a completed Form 470-2169 from the managed health care provider, the county office shall forward the form to the managed health care review committee within three working days.

a. Request for disenrollment by the recipient. In voluntary counties, the request shall be approved and acted upon within ten days of receipt by the managed health care contractor. In mandatory counties, a request for disenrollment shall be denied unless a choice of another managed health care provider is requested simultaneously or good cause can be demonstrated to the review committee. Examples of good cause include services received which were untimely, inaccessible, of insufficient quality, or inadequately provided by all of the contracting managed health care providers in the recipient's county of residence. If the recipient has not experienced the above conditions in all the other available managed health care programs, enrollment in one of the alternative managed health care programs shall be a condition of approving disenrollment.

b. Request for disenrollment by the PHP. With prior approval of the managed health care review committee, a request for disenrollment of an enrolled recipient may be approved when:

- (1) There is evidence of fraud or forgery in the use of PHP services or in the choice for PHP services.
- (2) There is evidence of unauthorized use of the PHP identification card.
- (3) Upon documentation, the PHP has been unable after reasonable efforts to establish or maintain a satisfactory physician-patient relationship with the recipient.

88.24(4) *Disenrollments by the department.* Disenrollments will occur when:

- a.* The contract between the department and the PHP is terminated.
- b.* The recipient becomes ineligible for Medicaid. If the recipient becomes ineligible and is later reinstated to Medicaid, enrollment in the PHP will also be reinstated.
- c.* The recipient permanently moves outside the PHP's enrollment area.
- d.* The recipient transfers to an eligibility group excluded from PHP enrollment. See definition of recipient in rule 441—88.21(249A).

e. The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

88.24(5) *No disenrollment for health reasons.* No recipient shall be disenrolled from a PHP because of an adverse change in health status.

441—88.25(249A) Covered services.

88.25(1) Amount, duration, and scope of services. Except as provided for in the contract, PHPs shall cover as a minimum all services covered by the Medicaid program as set forth in 441—Chapter 78.

88.25(2) Mandatory services.

a. Although the contract may specify additional services covered (with the exception of those defined in 88.25(3)), the PHP shall cover as a minimum the following services:

- (1) Inpatient hospital services.
- (2) Outpatient hospital services.
- (3) Physician services.
- (4) Family planning services.
- (5) Home health agency services.
- (6) Laboratory and X-ray services.
- (7) Early periodic screening, diagnosis and treatment for persons under age 21.
- (8) Rural health clinic services (where available).
- (9) Advanced registered nurse practitioners.

b. PHPs shall attempt to subcontract with all local family planning clinics funded by Title X moneys and all maternal and child health centers funded by Title V moneys.

c. According to the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, recipients enrolled in managed health care options (including PHPs) may seek family planning services anywhere without referral, even if they are minors. The PHP must pay any claims submitted by a provider of family planning services when the service has been provided to a recipient in a month for which a capitation rate has been paid on the recipient's behalf to the PHP by the department.

88.25(3) Excluded services. Unless specifically included in the contract, PHPs will not be required to cover long-term care (skilled nursing facilities, intermediate care facilities, residential care facilities, state resource centers, or intermediate care facilities for the mentally retarded), inpatient psychiatric care provided at the state-administered mental health institutes, services provided by the area education agencies, services provided at specialized adolescent psychiatric facilities, day treatment and partial hospitalization services for persons aged 20 or under, or the enhanced services provided to certain eligible recipients. Reimbursement to recipients for nonemergency medical transportation as described at rule 441—78.13(249A) will not be covered by the PHP; the department will continue to reimburse through its fee-for-service methodology for this service.

88.25(4) Restrictions and limitations. If the PHP covers a type of service which is also covered under Medicaid, the PHP may not impose any restrictions or limitations on that service more stringent than those applicable in Medicaid according to the provisions at 441—Chapter 78. The PHP may, at its discretion, offer services to its enrolled recipients beyond the scope of Medicaid as defined at 441—Chapter 78.

88.25(5) Recipient use of PHP services. An enrolled recipient must utilize PHP participating providers of service. No payment by the PHP will be made for services provided by non-PHP providers if the same type of service is available through the PHP under its contract with the department except as provided in subrule 88.25(2)“c,” and rule 441—88.26(249A).

441—88.26(249A) Emergency services.

88.26(1) Availability of services. The PHP will ensure that the services of a primary care physician are available on an emergency basis 24 hours a day, seven days a week, either through the PHP's own providers or through arrangements with other providers. In addition, the PHP must provide payment to nonparticipating providers within 60 days of receipt of the bill for all contracted services furnished by providers which do not have contractual arrangements with the PHP to provide services but which were needed immediately because of an injury or illness and in which case the illness or injury did not permit a choice of provider.

88.26(2) PHP payment liability. PHP payment liability on account of injury or emergency illness is limited to emergency care required before the recipient can, without medically harmful consequences, return to the enrollment area or to the care of a provider with whom the PHP has arrangements to provide

services. If an ambulance is necessary to transport the recipient to follow-up treatment, the PHP shall be financially liable. Benefits for continuing the follow-up treatment are provided only in the PHP's enrollment area.

If an enrolled recipient is injured or becomes ill and receives emergency services outside the PHP's enrollment area, the PHP shall pay the facility or person who provided the emergency care for emergency medical services and medical services, for inpatient hospital services in a general hospital as a result of the emergency, and for emergency ambulance service.

88.26(3) Notification and claim filing time span. The PHP may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers. However, failure to give notice or to file claims within those time limitations will not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible.

441—88.27(249A) Access to service.

88.27(1) Choice of provider. Recipients will have the opportunity to choose their health care professionals to the extent possible and medically appropriate from any of the PHP providers participating in the Medicaid contract.

88.27(2) Medical service delivery sites. Medical service delivery sites shall have the following specific characteristics:

a. Be located within 30 miles of and be accessible from the personal residences of enrolled recipients.

b. Have sufficient staff resources to adequately provide the medical services for which the contract is in effect including physicians with privileges at one or more acute care hospitals.

c. Have arrangements for services to be provided by other providers where in-house capability to serve specific medical needs does not exist.

d. Meet the applicable standards for participating in the Medicaid program.

e. Be in compliance with all applicable local, state, and federal standards related to the service provided as well as those for fire and safety.

88.27(3) Adequate appointment system. The PHP shall have procedures for the scheduling of patient appointments which are appropriate to the reason for the visit as follows:

a. Patients with urgent nonemergency needs shall be seen within one hour of presentation at a PHP medical service delivery site.

b. Patients with persistent symptoms shall be seen within 48 hours of reporting of the onset of the persistent symptoms.

c. Patient routine visits shall be scheduled within four to six weeks of the date the patient requests the appointment.

d. Scheduling of appointments shall be by specific time intervals and not on a block basis.

88.27(4) Adequate after hours call-in coverage. The PHP must have in effect the following arrangements which provide for adequate after hours call-in coverage:

a. Twenty-four-hour-a-day telephone coverage shall exist.

b. If a physician does not respond to the initial telephone call, there must be a written protocol specifying when a physician must be consulted. Calls requiring a medical decision shall be forwarded to the on-call physician and a response to each call which requires a medical decision must be provided within 30 minutes.

c. Notations shall be made in the patient's medical record of relevant information related to an after-hours call.

88.27(5) Adequate referral system. The PHP must effect the following arrangements which provide for an adequate referral system:

a. A network of referral sources for all services which are covered in the contract, but not directly provided by the PHP.

b. Procedures for the return of relevant medical information from referral sources including review of information by the referring physicians, entry of information into the patient's medical record, and arrangements for periodic reports from ongoing referral arrangements.

c. A notation in the medical record for hospitals' patients indicating the reason, date, and duration of hospitalization and entry of pertinent reports from the hospitalization and discharge planning in the medical record.

441—88.28(249A) Grievance procedures.

88.28(1) *Written procedure.* The PHP must have a written procedure by which enrolled recipients may express grievances, complaints, or recommendations, either individually or as a class and which:

- a. Is approved by the department prior to use.
- b. Acknowledges receipt of a grievance to the grievant.
- c. Sets time frames for resolution including emergency procedures which are appropriate to the nature of the grievance and which require that all grievances shall be resolved within 30 days.
- d. Ensures the participation of persons with authority to require corrective action.
- e. Includes at least one level of appeal.
- f. Ensures the confidentiality of the grievant.

88.28(2) *Written record.* All grievances, including all informal or verbal complaints, which must be referred or researched for resolution must be recorded in writing. A log of the grievances must be retained and made available at the time of audit and must include progress notes and method of resolution.

88.28(3) *Information concerning grievance procedures.* The PHP's written grievance procedure must be provided to each newly enrolled recipient not later than the effective date of coverage.

88.28(4) *Appeals to the department.* A recipient who has exhausted the grievance procedure of the PHP may appeal the issue to the department under the provisions of 441—Chapter 7. Instances where the substance of the grievance relates to department policy shall be appealed directly to the department.

88.28(5) *Periodic report to the department.* The PHP shall make quarterly reports to the department summarizing grievances and resolutions as specified in the contract.

441—88.29(249A) Records and reports.

88.29(1) *Medical records system.* The PHP shall comply with the provisions of rule 441—79.3(249A) regarding maintenance and retention of clinical and fiscal records and, in addition, the PHP must maintain a medical record system which:

- a. Identifies each medical record by the departmentally assigned state identification number.
- b. Identifies the location of every medical record.
- c. Places medical records in a given order and location.
- d. Provides a specific medical record on demand.
- e. Maintains the confidentiality of medical records information and releases the information only in accordance with established policy pursuant to subrule 88.29(3).
- f. Maintains inactive medical records in a specific place.
- g. Permits effective professional review in medical audit processes.
- h. Facilitates an adequate system for follow-up treatment including monitoring and follow-up of off-site referrals and inpatient stays.
- i. Meets state and federal reporting requirements applicable to PHPs.

88.29(2) *Content of individual medical record.* The PHP must have in effect arrangements which provide for an adequate medical record-keeping system which includes a complete medical record for each enrolled recipient in accordance with provisions set forth in the contract.

88.29(3) *Confidentiality of records.* PHPs must maintain the confidentiality of medical record information and release the information only in the following manner:

- a. All medical records of enrolled recipients shall be confidential and shall not be released without the written consent of the enrolled recipients or the responsible party acting on behalf of the enrolled recipient.

b. Written consent is not required for the transmission of medical record information to physicians, other practitioners, or facilities which are providing services to enrolled recipients under a subcontract with the PHP. This provision also applies to specialty providers who are retained by the PHP to provide services which are infrequently used or are of an unusual nature.

c. Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care pursuant to rule 441—89.26(249A).

d. Written consent is required for the transmission of medical record information of a former enrolled recipient to any medical provider not connected with the PHP.

e. The extent of medical record information to be released in each instance shall be based upon tests of medical necessity and a “need to know” on the part of the practitioner or facility requesting the information.

f. Medical records maintained by subcontracting providers must meet the requirements of this rule.

88.29(4) Reports to the department. Each PHP shall submit reports to the department as follows:

a. Annual audited financial statements no later than 120 days after the close of the PHP’s fiscal year.

b. Periodic financial, utilization, and statistical reports as required by the department under the contract.

88.29(5) Audits. The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means, the quality, appropriateness, and timeliness of services performed by the PHP. The department or HHS may audit and inspect any records of a PHP, or the subcontractors of a PHP, which pertain to services performed and the determination of amounts paid under the contract. These records will be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.30(249A) Marketing.

88.30(1) Marketing procedures. All marketing plans, procedures, and materials used by the PHP must be approved in writing by the department prior to use. Random door-to-door marketing of low-income families or the offering of financial incentives will not be approved.

88.30(2) Marketing representatives. Marketing representatives utilized to market Medicaid recipients must be sufficiently trained and capable of performing marketing activities within the requirements of the contract. The PHP’s marketing representatives must represent the PHP in an honest and straightforward manner. In its marketing presentations, the PHP must include information which ensures that the representative is not mistaken for a department employee. Marketing presentations which intentionally belittle or maliciously downplay the benefit package, services, or providers of another participating managed health care option will not be approved.

88.30(3) Marketing presentations. The PHP may make marketing presentations in the local office(s) of the department or otherwise include the department in marketing efforts at the discretion of the department.

88.30(4) Marketing materials. Written material must include a marketing brochure or a member handbook which fully explains the services available, how and when to obtain them, and special factors applicable to enrolled recipients as specified in the contract.

441—88.31(249A) Patient education.

88.31(1) Use of services. The PHP shall have procedures in effect to orient enrolled recipients in the use of services the PHP is contracting to provide. This includes what to do if the recipient requires medical care while out of the enrollment area, a 24-hour-a-day telephone number, appropriate use of the referral system, grievance procedures, and how emergency treatment is to be provided.

88.31(2) Patient rights and responsibilities. The PHP shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrolled recipients. This statement may be part of an informational brochure provided to all new enrollees. The right of the enrolled recipient to request disenrollment must be included.

441—88.32(249A) Payment to the PHP.

88.32(1) *Capitation rate.* In consideration for all services rendered by a PHP under a contract with the department, the PHP will receive a payment each month for each enrolled recipient. This capitation rate represents the total obligation of the department with respect to the costs of medical care and services provided to enrolled recipients under the contract.

88.32(2) *Determination of rate.* The capitation rate is actuarially determined by the department for the beginning of the new fiscal year using statistics and data about Medicaid fee-for-service expenses for PHP-covered services to a similar population during the preceding fiscal year. (For example, fiscal year 1990 rates are predicted with fiscal year 1988 dates of service for Medicaid fee-for-service expenditures.) The capitation rate may not exceed the cost to the department of providing the same services on a fee-for-service basis to an actuarially equivalent nonenrolled population group. A 1 percent incentive will be available to PHPs who contract to cover all services except those specified in subrule 88.25(3). PHPs electing to share risk with the department will have their payment rates reduced by an amount reflecting the department's experience for high cost fee-for-service recipients.

88.32(3) *Amounts not included in rate.* The capitation rate does not include any amounts for the recoupment of losses suffered by the PHP for risks assumed under the current or any previous contract. The PHP accepts the rate as payment in full for the contracted services. Any savings realized by the PHP due to lower utilization from a less frequent incidence of health problems among the enrolled population shall be wholly retained by the PHP.

88.32(4) *Third-party liability.* If an enrolled recipient has health coverage or a responsible party other than the Medicaid program available for purposes of payment for medical expenses, it is the right and responsibility of the PHP to investigate these third-party resources and attempt to obtain payment. The PHP shall retain all funds collected through third-party sources. A complete record of all income from these sources must be maintained and made available to the department.

441—88.33(249A) Quality assurance. The PHP shall have in effect an internal quality assurance system that meets the requirements of 42 CFR 434.44 as amended to December 31, 1996, and a system of periodic medical audits meeting the requirements of 42 CFR 434.53 as amended to December 13, 1990.

441—88.34 to 88.40 Reserved.

DIVISION III
MEDICAID PATIENT MANAGEMENT

441—88.41(249A) Definitions.

“Contract” shall mean a contract between the department and a Medicaid-participating provider or clinic as specified in rule 441—88.44(249A) and subrule 88.45(1) for the purpose of providing patient management to enrolled recipients.

“Covered eligibles” shall mean those groups of Medicaid-eligible recipients specified in subrule 88.42(1) who are eligible to receive services under patient management.

“Department” shall mean the Iowa department of human services.

“Designee” shall mean an organization designated by the department of human services to act on behalf of the department in the administration of Medicaid managed health care.

“Eligible providers” shall mean those providers specified in rule 441—88.44(249A) and subrule 88.45(1) with whom the department may contract to be patient managers.

“Emergency care” shall mean those medical services rendered for an emergent medical condition or protection of the public health.

“Emergent medical condition” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect it to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

2. Serious impairment to bodily functions, or
3. Serious dysfunction of any bodily organ or part.

The determination of whether an emergent medical condition exists shall be decided by a medical professional and shall be based on the patient's medical condition including presenting symptoms and medical history (as related to severe pain) prior to treatment.

In cases where the above criteria are satisfied, no prior authorization procedures are allowed.

"Enrolled recipient" shall mean a covered eligible who has been enrolled with a patient manager according to procedures set forth in rule 441—88.46(249A).

"Extended-participation program" shall mean mandatory six-month enrollment period with a managed care entity.

"Grievance" shall mean a complaint expressed verbally or in writing by an enrolled recipient or provider relative to services under patient management. A grievance at the informal level is one which can be resolved by short-term intervention on the part of the department or its designee via the toll-free managed health care telephone line or through informational correspondence. A formal grievance is one which must be taken to another level for quality of care or policy determination.

"Managed care entity" shall mean either a managed care organization licensed by the department of insurance (e.g., HMO or PHP) or a primary care case management program (i.e., MediPASS).

"Managed health care" shall mean any of the options for alternative delivery of Medicaid services that provides coordinated delivery of health care. The current options offered by the department are Medicaid patient management, known as MediPASS, health maintenance organization (HMO) enrollment and prepaid health plan (PHP) enrollment.

"Managed health care review committee" shall mean a committee composed of representatives from the department and its designee. The committee shall review and render decisions on all requests for disenrollment from managed health care that are not automatically approvable, all requests for exception to eligible provider provisions, and other exceptions to managed health care procedures.

"Mandatory enrollment" shall mean a mandatory participation in managed health care as specified in subrule 88.46(1).

"Mandatory project county" shall mean a county where the department has contracts with more than one managed care entity, one of which may be primary care case management (MediPASS) in cases where the number of MediPASS providers willing to serve as patient managers is sufficient to meet the needs and makeup of the recipient population in the county, or where the department has implemented the MediPASS program alone in the county.

"Managed services" shall mean services as specified in subrule 88.48(1) that require preauthorization from the patient manager in order to be payable by Medicaid.

"Medical service area" means a geographic area within which recipients must reside in order to enroll in the managed health care MediPASS option.

"MediPASS" shall mean Medicaid patient access to service system and shall be the acronym used to identify the Medicaid patient management program.

"Nonmanaged services" shall mean services as specified in subrule 88.48(2) that do not require authorization by the patient manager in order to be payable by Medicaid.

"Patient management" shall mean the provision of services to enrolled recipients by a patient manager in accordance with the contract.

"Patient manager" shall mean an eligible provider who has signed a contract with the department to perform patient management for enrolled recipients.

"Urgent care" shall mean those medical services rendered for an urgent medical condition or protection of the public health.

"Urgent medical condition" shall mean a medical condition manifesting itself by acute symptoms that are of lesser severity (including severe pain) than that recognized for an emergent medical condition, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the illness or injury to result in:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in jeopardy,

2. Impairment to bodily functions, or
3. Dysfunction of any bodily organ or part.

If the recipient is assigned to a patient manager (e.g., MediPASS or HMO), the patient manager shall arrange for necessary care within 24 hours by either providing it or referring and authorizing another appropriate provider to provide care.

441—88.42(249A) Eligible recipients.

88.42(1) *Included categories of assistance.* All categories of Medicaid-eligible recipients except those specified as excluded in subrule 88.42(2) are required to participate in Medicaid managed health care if they reside in a mandatory project county as described in subrule 88.43(1). Recipients who reside in a voluntary project county as described in subrule 88.43(2) may participate if they so choose.

A choice to enroll in any other form of Medicaid managed health care available in the recipient's county of residence shall fulfill the requirements to participate in mandatory project counties.

88.42(2) *Excluded categories of assistance.* The following categories of Medicaid-eligible recipients shall not be allowed to participate in Medicaid patient management in either mandatory or voluntary project counties:

- a. Medically needy recipients as defined in 441—subrule 75.1(35).
- b. Recipients over age 65 and under age 21 in psychiatric institutions as defined in 441—Chapter 85.
- c. Recipients who are supplemental security income-related case members.
- d. Rescinded IAB 10/3/01, effective 12/1/01.
- e. Automatic redetermination recipients as defined in rule 441—76.11(249A).
- f. Recipients who are foster care and subsidized adoption-related case members.
- g. Recipients who are Medicare beneficiaries.
- h. Pregnant women who are determined presumptively eligible in accordance with provisions in 441—subrule 75.1(30).
- i. Recipients who are Native American Indians or Alaskan natives.
- j. Recipients who are receiving services from a Title V provider.

441—88.43(249A) Project area.

88.43(1) *Designation as a mandatory project county.* The department shall designate mandatory enrollment counties included in the project. In order for a county to be considered a mandatory project county, the number of MediPASS providers willing to serve as patient managers shall be sufficient to meet the needs of the size and makeup of the recipient population in the county, and the county shall be included in the department's freedom of choice waiver from the Centers for Medicare and Medicaid Services.

88.43(2) *Voluntary project counties.* The department shall designate voluntary enrollment counties included in the project. A county may be voluntary where provider participation is not sufficient to be designated mandatory but providers may choose to participate on a voluntary enrollment basis.

88.43(3) *Expansion to other counties.* Rescinded IAB 11/10/93, effective 11/1/93.

441—88.44(249A) Eligible providers.

88.44(1) *Specialties allowed.* Providers shall be allowed to contract with the department to provide patient management to enrolled recipients as long as the provider:

- a. Is a licensed doctor of medicine or osteopathy or an advanced registered nurse practitioner licensed pursuant to Iowa Code chapter 152 and possessing evidence of certification pursuant to board of nursing rules under 655—Chapter 7 in a specialty area listed in paragraph 88.44(1)“d.”
- b. Is otherwise eligible to enroll as an Iowa Medicaid provider.
- c. Is a provider in good standing with the Medicaid agency as defined in subrule 88.45(1).
- d. Is practicing in one of the following specialties in the medical services area:
 - (1) Family practice.
 - (2) General practice.

- (3) Pediatrics.
- (4) Internal medicine.
- (5) Obstetrics and gynecology.

88.44(2) Clinic or group practice participation. A provider may participate as an individual practitioner or as a partner or employee of a clinic or group practice. The clinic or group shall be the contractor. Federally qualified health centers and rural health clinics that employ providers in the specialties specified in subrule 88.44(1) may contract. However, each provider participating within the clinic, group, federally qualified health center, or rural health clinic shall sign and be bound by the terms of the clinic or group contract as if the provider was in individual practice.

88.44(3) Exceptions. Other providers licensed as doctors of medicine or osteopathy or as advanced registered nurse practitioners may request exception to subrule 88.44(1) for specific individual patients in accordance with the procedures set forth in this subrule.

a. If the request is being made in order to allow a different type of specialist to be a patient manager, or to allow a provider practicing outside the recipient's medical service area to serve the recipient, the provider shall make a written request to the department.

(1) The request shall identify the provider by name, address, telephone number, specialty, and Medicaid provider number, indicating the practice location, or date of application to be a Medicaid provider. The request shall specify the members in question and state agreement to provide primary care and patient management as specified in subrule 88.45(2) to those members.

(2) If the request comes initially from the recipients as specified in paragraph 88.46(2) "c," the department shall contact the provider in question to offer the provider the opportunity to request the exception.

b. Rescinded IAB 11/10/93, effective 11/1/93.

c. Rescinded IAB 11/10/93, effective 11/1/93.

d. The managed health care review committee shall consider the request and respond within ten working days of receipt of the request. If the request is approved, a contract will be forwarded to the physician and procedures for contracting with a physician as specified in rule 441—88.45(249A) shall be followed.

e. The following factors shall be taken into account when considering the physician's request:

- (1) Mutual agreement between physician and patient regarding the arrangement.
- (2) Existence of an already established physician-patient relationship.
- (3) Transportation barriers, if requesting a patient manager outside the medical service area.
- (4) Customary practice by the specialist to provide primary care.
- (5) A new medical condition which necessitates the proposed physician-patient relationship.

441—88.45(249A) Contracting for the provision of patient management.

88.45(1) Eligibility to contract. Only Medicaid-participating providers and clinics in good standing shall be eligible to contract with the department to provide patient management.

88.45(2) Contract provisions. The department shall enter into a contract arrangement with all providers who are eligible as specified in rule 441—88.44(249A) and who wish to provide patient management. Form 470-2615, Agreement for Participation as a Primary Care Physician Patient Manager in the Medicaid Patient Access to Service System, shall be the form designated as the contract. At a minimum, the contract shall include provisions as follows:

a. The patient manager shall provide managed health care to enrolled recipients by providing primary health care and providing or referring the patient appropriately and authorizing payment for all other care covered under the program as specified in subrule 88.48(1). The patient manager is also responsible for monitoring and coordinating all covered care.

b. The patient manager shall provide or arrange for 24-hour-per-day, seven-day-per-week provider availability to enrolled recipients.

c. The patient manager shall maintain records that at a minimum:

- (1) Identify the patient as a patient management recipient.

(2) Document all authorizations for medical services provided by other providers and the extent of those authorizations.

(3) Contain the name, state identification number, age, sex and address of the patient.

(4) Document services provided and where and by whom they are provided.

(5) Contain medical diagnosis, treatment, therapy and drugs prescribed or administered.

(6) Contain the name of the person making the entry and the date of the contact.

d. The patient manager shall review and take action upon periodic utilization review reports, according to instructions that the department will provide each patient manager.

e. The department shall specify the fees and method of payment to patient managers.

f. The department shall specify the manner in which providers shall be notified of the recipients enrolled with them.

88.45(3) *Contract compliance.* The department shall put into place procedures for the monitoring of contract compliance on the part of patient managers to ensure appropriate access to adequate quality care. Those procedures may include, but are not limited to, on-site review of medical records by appropriate professional medical personnel and review of utilization patterns of participating patient managers. The procedures shall also include establishment of a grievance procedure defined in rule 441—88.49(249A).

88.45(4) *Corrective action and sanctions.* The department shall establish procedures for corrective action and sanctions when monitoring activities reveal possible contract noncompliance.

88.45(5) *Termination of contract.* The contract may be terminated in any of the following ways:

a. The patient manager may terminate the contract or a clinic may remove a provider from a clinic contract by providing the department with written notice of the desire to terminate the contract 60 days in advance of the desired date of termination in order to allow the department or its designee time to disenroll and reenroll the MediPASS patients with other patient managers.

(1) In no situation shall the provider stop providing patient management or primary care to the patient until the patient can be reenrolled with another provider except as specified in subrule 88.48(4).

(2) Failure to provide the specified period of notice or failure to continue providing patient management or primary care before the reenrollment shall result in forfeiture of all remaining patient management fees that would otherwise have been due the patient manager.

b. The department may terminate the contract with the patient manager with 60 days' advance notice for any of the following reasons:

(1) The department has imposed any sanction described at 441—subrule 79.2(3).

(2) Recommendations of contract termination made in accordance with the procedures described in rule 441—88.51(249A), after opportunity for corrective action has been unsuccessful or rejected by the patient manager in question.

Sixty days' advance notice is not required for situations described in subrule 88.48(4).

c. Any patient manager who has had a contract terminated by the department shall have the right to appeal the termination as provided in 441—Chapter 7.

441—88.46(249A) Enrollment and changes in enrollment.

88.46(1) *Mandatory enrollment.* Participation in managed health care, if available, is required for covered eligibles as specified in subrule 88.42(1) who reside in a mandatory project county. The department shall require, whenever administratively feasible, that all eligible recipients enroll with a managed care entity. Administrative feasibility is determined by whether a freedom-of-choice waiver or state plan amendment has been approved by the Centers for Medicare and Medicaid Services and whether the managed care entities demonstrate sufficient access to and quality of services.

88.46(2) *Enrollment procedures.* In mandatory enrollment counties, recipients shall be required to choose their managed health care provider. When no choice is made by the recipient, the recipient will be assigned to a contracting health maintenance organization (HMO) serving the recipient's county of residence when an HMO is available or to a MediPASS patient manager on a rotating basis to ensure an equitable distribution between the HMO and MediPASS programs based on the number of managed health care options (MediPASS and HMOs) available in the county. In the event there is no contracting

HMO serving the recipient's county of residence in a mandatory enrollment county, the recipient shall be assigned to a MediPASS patient manager.

Within the MediPASS option, recipients shall be assigned according to age appropriateness. Whenever possible, family units shall be assigned to the same provider that an enrolled family member has selected, if that provider is appropriate according to age parameters. MediPass patient managers shall not be assigned more recipients than their self-imposed maximum or the maximum described in subrule 88.46(5), whichever is lower.

Recipients who are assigned a managed care entity as described in this subrule shall have at least ten days in which to request enrollment in a different available entity. The change is subject to provisions in subrule 88.46(4) dealing with the effective date.

a. Timely notice. Recipients shall be sent timely notice of the managed health care assignment. The recipient shall have a minimum of ten days in which a change to the assigned managed care entity can be made. The notice shall include the name of the managed care entity to whom the recipient shall be assigned if the recipient does not make a different selection by the date specified in the notice. If the covered eligible does not make a selection before the due date, the recipient shall be enrolled with the managed care entity listed on the notice.

b. Enrollment. Enrollment in managed health care shall be discussed during the face-to-face interview with all applicants for Medicaid under covered categories of assistance in mandatory or voluntary enrollment areas. The applicant shall be shown an informational videotape and encouraged to make a selection of a managed care entity. Applicants in mandatory enrollment areas shall be informed that should the applicant become eligible for a managed health care selection, one shall be assigned. Covered eligibles who are not enrolled shall be sent a notice of their managed health care assignment when the recipient:

- (1) Attains initial eligibility for a covered category of service in a mandatory project county.
- (2) Changes from an excluded category of assistance to a covered category of assistance in a mandatory project county.
- (3) Is receiving a covered category of assistance and moves from a county where no managed health care is available or voluntary project county to a mandatory project county.
- (4) Reattains eligibility.
- (5) Has a new member of the household receiving a covered category of assistance.

If the covered eligible in a mandatory project county does not make another selection before the due date specified in the notice, the covered eligible shall be enrolled with the managed health care provider listed on the notice.

c. Selection of a managed health care provider. A list of managed health care providers participating in managed care entities serving the county shall be available to recipients for use in selecting a provider. If the recipient wishes to request an exception to the list of available managed health care providers as described in subrule 88.44(3), the managed health care review committee shall make a determination on the exception request. While the determination is being made, the recipient's enrollment shall be placed in a pending status.

d. Rescinded IAB 5/7/97, effective 7/1/97.

e. Request to change enrollment. An enrolled recipient may, within 90 days from timely notice, request to change enrollment from one managed health care provider to another or one managed care entity to another. The request shall be made on a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department. Changes are subject to the provisions of subrule 88.46(3) dealing with effective date.

f. Managed care entity extended-participation program (EPP). After the initial 90 days from timely notice, recipients will remain enrolled with the chosen provider for the following six months, with three exceptions:

- (1) A request for disenrollment by recipient for good cause pursuant to paragraph 88.4(3) "a."
- (2) A request for disenrollment by provider for good cause pursuant to paragraph 88.4(3) "b."
- (3) Availability of a new, previously unavailable, managed care entity. In this instance recipients will be allowed to select that entity for the remainder of the current EPP period.

g. Enrollment cycle. Prior to the end of any extended-participation program (EPP) period, recipients will be notified of their ability to enroll with a different managed care option. A change in enrollment or failure to change enrollment will begin a new EPP enrollment period at the end of the current EPP.

88.46(3) Voluntary enrollment procedures. Voluntary enrollment procedures shall be the same guidelines as mandatory enrollment procedures except:

- a.* Recipients shall not be informed at the face-to-face interview that enrollment is required.
- b.* Notice to recipient shall not include assignment language.
- c.* Recipients shall not be assigned if no selection is made voluntarily.
- d.* A managed health care provider must be available for enrollment.

88.46(4) Effective date. Enrollment or changes in enrollment shall always be effective on the first day of a month. The effective date of enrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives a choice as specified in subrules 88.46(1) and 88.46(2) or the deadline given a recipient to indicate the recipient's managed health care choice, whichever is applicable. The effective date shall be earlier where computer cutoff allows.

88.46(5) Identification card. The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to all enrolled recipients.

Providers of medical services shall access the department's eligibility verification system (ELVS) via telephone or access the department's secure Web site at the time of service in order to establish that the patient is Medicaid-eligible and whether the services being provided require the authorization of the patient manager.

88.46(6) Enrollment limits.

a. Unless one or more of the following special situations exist, enrollment shall be limited to 1500 enrollees per full-time patient manager with an additional 300 enrollees allowed for each full-time nurse practitioner or physician's assistant employed by the MediPASS provider or clinic:

- (1) The provider treats a disproportionate share of Medicaid patients in the provider's current practice.
- (2) A special group practice arrangement exists with a demonstrated ability to manage a large number of enrollees.
- (3) Other exceptional situations may be considered as special demonstration projects on a case-by-case basis.

b. Patient managers wishing to receive consideration for one of these special situations must make a request for consideration in writing to the department and provide sufficient documentation that they fit one or more of the special situations.

c. Providers or clinics may set a lower self-imposed maximum number of enrollees at the time they sign the initial contract and may revise that number by notifying the department or its designee in writing.

(1) If the patient manager decreases the patient manager's own maximum to a number below which the patient manager currently has enrolled, the patient manager must continue to serve those recipients until normal disenrollments put the provider below the provider's new maximum.

(2) No minimum number of enrollees shall be required.

88.46(7) Reinstatement of patient management status. When an enrolled recipient loses Medicaid eligibility and is subsequently reinstated before the effective date of cancellation, the enrollment in patient management will also be reinstated.

441—88.47(249A) Disenrollment.

88.47(1) Disenrollment request. An enrolled recipient may be disenrolled from a patient manager in one of three ways:

a. The enrolled recipient may request disenrollment by completing a choice form designated by the department, in writing, or by telephone call to the toll-free recipient managed health care telephone line maintained by the department at any time prior to enrollment with a managed health care entity and within the 90 days from the date of the enrollment notice. After this time period, a recipient may be

disenrolled for good cause when the recipient can demonstrate that services were untimely, inaccessible, of insufficient quality, or inadequately provided. If the recipient is a covered eligible specified in subrule 88.42(1) as a mandatory participant, the recipient's disenrollment request shall not be approved until another patient manager or managed health care option is chosen.

b. The patient manager may request that an enrolled recipient be disenrolled by completing Form 470-2169, Managed Health Care Provider Request for Recipient Disenrollment.

(1) Disenrollment may be approved for good cause, such as but not limited to inability after reasonable effort to establish or maintain a satisfactory provider-patient relationship with the recipient. Documentation of the reason for disenrollment shall be included with or attached to the disenrollment request.

(2) The department shall respond within 30 days as to whether the disenrollment request is approved.

(3) If the request is approved, the patient manager shall continue to serve a mandatory recipient until the recipient can be enrolled with another patient manager or another managed health care option. In no case shall that time exceed 60 days from the date of receipt of the form.

c. The department may disenroll an enrolled recipient in the following situations:

(1) The contract with the patient manager is terminated.

(2) The patient manager dies, retires or leaves the medical service area.

(3) The recipient loses Medicaid eligibility. If the recipient regains eligibility as specified in subrule 88.46(7), the enrollment to patient management will be automatically reinstated.

(4) The recipient moves to a nonproject county.

(5) The recipient's eligibility changes to a category of assistance as specified in subrule 88.42(2) that is excluded from participation in patient management.

(6) The department has determined that participation in the HIPP (Health Insurance Premium Payment) program as described in rule 441—75.21(249A) is more cost-effective than enrollment in managed health care.

(7) The department has determined that the recipient's enrollment in the recipient lock-in program, as defined in 441—Chapter 76, would be more cost-effective for the department.

The department shall request that recipients whose participation is mandatory as specified in subrule 88.42(1) select a new patient manager or other managed health care option if disenrollment is for reasons listed in 88.47(1) "c" (1) or (2). If the recipient does not make the selection the recipient will be assigned a new patient manager by the department.

88.47(2) Effective date. Disenrollment shall always be effective on the first day of a month. The effective date of disenrollment shall be no later than the first day of the second month subsequent to the date the department or its designee receives an enrollment change request as specified in subrule 88.47(1) or the date the department approves a disenrollment request from a physician or the date the department becomes aware of an event which causes the department to disenroll an enrolled recipient, whichever is applicable. The effective date shall be earlier whenever possible.

441—88.48(249A) Services.

88.48(1) Managed services. Provision of the following services by any provider other than the patient manager requires authorization from the patient manager in order to be payable by Medicaid except that mental health and substance abuse services for all managed health care recipients are provided under the Iowa Plan program and do not require authorization (see rule 441—88.61(249A)):

a. Inpatient hospital.

b. Outpatient hospital.

c. Home health.

d. Physician (except services provided by an ophthalmologist).

e. Clinic (rural health clinic, federally qualified health center, maternal health center, ambulatory surgical center, birthing center).

f. Laboratory, X-ray.

g. Medical supplies.

- h.* Physical therapy, audiology, rehabilitation agency, advanced registered nurse practitioner.
- i.* Rescinded IAB 11/5/97, effective 1/1/98.
- j.* Podiatric.

These services require authorization even if the need for the service is considered urgent. However, in case of urgent medical conditions, the patient manager shall arrange for necessary care within 24 hours by either providing it or referring to and authorizing another appropriate provider to provide care.

88.48(2) *Nonmanaged services.* Provision of any services not listed in subrule 88.48(1) does not require authorization from the patient manager in order to be payable by Medicaid.

88.48(3) *Authorizing managed services.* The patient manager may make referrals to another provider for specialty care or for primary care during the patient manager's absence or nonavailability.

a. No special authorization or referral form is required, and referrals should occur in accordance with accepted practice in the medical community. To ensure that payment is made for properly authorized services, the patient manager shall provide the specialist or other provider with the patient manager's Medicaid provider number (the national provider identifier number or Iowa-specific provider identifier number), which must be entered on the billing form to signify that the service has been authorized.

b. After the patient manager's initial referral of a patient to a specialist for ongoing treatment, the specialist shall not be required to receive further specific authorizations for the duration of the illness, or at the discretion of the patient manager, for a period of time specified by the patient manager.

c. The referral shall include necessary services rendered by the specialist and referrals for related services made by the specialist. With the patient manager's approval, the patient manager's number may be relayed by the referred specialist to other providers considered necessary for proper treatment of the patient. All authorizations and referrals shall be documented by both the patient manager and the referred-to provider in the patient's medical record.

d. Emergency services are excluded from the authorization requirement, even though these services may be ones customarily requiring authorization under patient management. Urgent care requires authorization in order for Medicaid services to be paid. The unauthorized use of a patient manager's authorization number shall be considered to be a false or fraudulent claim submission and may subject the provider to recoupment or to sanctions described at 441—subrule 79.2(3).

88.48(4) *Special authorizations.* Special authorization for the provision of managed services shall be given to providers by the department in situations such as, but not limited to, the death of the enrolled recipient's patient manager, the patient manager has left medical practice, moved from the medical service area or has been removed as a Medicaid provider and the department has not yet been able to establish a new patient manager or other managed health care option for the recipient. The procedure for obtaining this special authorization shall be specified in the provider handbook. The special authorization procedures shall only be used until the department is able to enroll the recipient with another patient manager or managed health care option. Additionally, special authorizations may be given when contracting patient managers fail to comply with contract provisions such as, but not limited to, failure to maintain 24-hour access as specified in subrule 88.45(2), paragraph "b."

441—88.49(249A) *Grievance procedure.* The department shall establish a procedure whereby enrolled recipients or providers may express complaints or concerns either verbally or in writing specific to managed health care services.

88.49(1) *Written record.* The department or its designee shall maintain a written record of all grievances. A log shall be maintained that includes the date of the grievance, member name and state identification number, provider name and national provider identifier number or Iowa-specific provider identifier number, nature of complaint, resolution and date of resolution.

88.49(2) *Formal grievance resolution and response.* The department or its designee shall record the facts involved in all grievances. Pertinent facts shall be obtained, as necessary and appropriate, from interviews with involved parties, on-site visits and consultation with professional medical consultants or an education and review committee. The department or its designee shall respond to all grievances within 15 working days of receipt. The response shall be in writing and copies shall be provided to the

recipient, the provider and to the department's patient manager file. Appeal rights shall be included in the response.

88.49(3) *Repeated grievances.* Providers or recipients who file repeated grievances, or providers or recipients against whom repeated grievances are filed, will be reviewed in-depth and a possible on-site visit will be made to resolve any misunderstandings as to patient management policies and procedures.

88.49(4) *Quality of care grievances.* In grievances involving quality of care, the case shall be referred to appropriate persons or agencies, including the board of medicine, for investigation.

88.49(5) *Information concerning grievance procedures.* The department grievance procedure shall be published on appropriate forms and brochures for the information of recipients and in provider handbooks for the information of patient managers and other providers.

88.49(6) *Appeals to the department.* A recipient who has exhausted the formal grievance procedure may appeal the issue to the department under the provisions of 441—Chapter 7.

441—88.50(249A) Payment.

88.50(1) *Fee.* Patient managers shall be paid a monthly fee of \$2 per enrolled recipient for the provision of patient management, including referrals. Payment for other services rendered shall be reimbursed in accordance with rules governing Medicaid payment. Providers such as federally qualified health centers who are reimbursed on a 100 percent of cost basis are not eligible to receive patient management fees separate from other reimbursement.

88.50(2) *Basis for payment.* Payment shall be based on the number of recipients enrolled with the patient manager as of automated benefit calculation system cutoff day in the month for which payment is being calculated.

88.50(3) *Mode of payment.* The provider shall be paid individually unless a clinic or group practice elects to receive payment for all providers participating under the clinic or group contract. The same mode of payment must be used for both patient management and regular Medicaid claims.

88.50(4) *Payment limit.* Payment shall be limited to \$3000 per month per patient manager no matter how many recipients are enrolled with the patient manager.

441—88.51(249A) Utilization review and quality assessment. Patient managers shall be monitored to ensure that recipients are able to access quality care and that utilization patterns and costs fall within acceptable standards. If overutilization or underutilization is apparent or quality of management service is inadequate, efforts shall be made to determine the reason and resolve problems, as necessary.

88.51(1) *Measured services.* Cost and units of service data will be reviewed for selected categories of service. This data shall be used to monitor overall utilization patterns and compare peer utilization patterns.

88.51(2) *Reports to patient managers.* Utilization information shall be provided on a periodic basis to patient managers to enable them to review their own utilization patterns and to review utilization by their enrollees. Patient managers will be responsible for reporting any discrepancies detected in this information to the department. The patient manager will be responsible for attempting to correct utilization behavior of recipients who appear from utilization reports to be inappropriate utilizers of medical services.

88.51(3) *Managed health care advisory committee.* Participating managed health care providers will be invited to assist the department or its agent in establishing and assessing goals of the state's Medicaid managed health care program. The department shall form a managed health care advisory committee made up of persons deemed appropriate by the department to review, advise and plan managed care goals with the department. Members may include representatives of MediPASS providers, HMO providers, FQHC providers, RHC providers, association representatives, and other public agencies as deemed appropriate by the department. The committee's functions may include, but are not limited to, the following:

a. Assist the department in developing procedures and parameters for utilization review and conduct further review of the utilization of patient managers whose pattern of utilization falls outside established parameters.

- b. Assist the department in establishing options for managed health care quality assessment.
- c. Assist the department in reviewing and making recommendations for action on quality of service-related grievances under the grievance procedure outlined in rule 441—88.49(249A).
- d. Assist the department in developing corrective action steps and recommendations for managed health care providers who have identifiable utilization or quality of management service deficiencies.
- e. Assist the department in developing standards and procedures for managed health care providers to use in performing review functions.
- f. Prepare or provide educational or informative articles to be used for patient education and health promotion.

441—88.52(249A) Marketing. A MediPASS provider may not distribute directly or through any agent or independent contractor marketing materials without the prior approval of the department, and may not distribute marketing materials that contain false or materially misleading information.

88.52(1) Service market. A MediPASS provider shall distribute any marketing materials to the entire service area or region.

88.52(2) Prohibition of “cold-call” marketing. MediPASS providers shall not, directly or indirectly, conduct door-to-door, telephonic, or other “cold-call” marketing of enrollment.

441—88.53 to 88.60 Reserved.

DIVISION IV
IOWA PLAN FOR BEHAVIORAL HEALTH

441—88.61(249A) Definitions.

“*Accredited*” shall mean an entity approved by the division of mental health and disability services of the department to provide mental health services.

“*Appeal*” shall mean the process defined in 441—Chapter 7 by which a Medicaid member, or the member’s designee, may request review of a certain decision made by the department or the contractor.

“*ASAM-PPC-2R*” shall mean the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance Related Disorders, Second Edition Revised, published by the American Society of Addiction Medicine in 2001.

“*Assertive community treatment (ACT) program*” shall mean a program of comprehensive outpatient services provided in the community directed toward the amelioration of symptoms and the rehabilitation of behavioral, functional, and social deficits of persons with severe and persistent mental disorders and persons with complex symptomatology who require multiple mental health and supportive services to live in the community.

“*Capitation rate*” shall mean the fee the department pays monthly to the contractor for each enrolled Medicaid member for the provision of covered, required, and optional services, whether or not the enrollee received services during the month for which the fee is paid.

“*Certification*” shall mean the process of determining that a facility, equipment or an individual meets the requirements of federal or state law.

“*Clinical decision review*” shall mean the process by which enrollees and participating and nonparticipating providers may request a review by the contractor of a decision made by an employee of the contractor regarding the prior authorization, denial, or payment for services.

“*Contract*” shall mean the contract between the department and the entity or entities selected by the department to implement the Iowa Plan. Contract sections related to Medicaid-funded services shall be interpreted to meet the requirements of the Code of Federal Regulations, Title 42, Part 434 as amended to December 31, 1996. The department of public health also shall be party to the contracts in relationship to the provision of substance abuse services to non-Medicaid persons served through the Iowa Plan.

“*Contractor*” shall mean each entity with whom the department contracts to provide covered, required and optional services for those members enrolled in the Iowa Plan.

“*Coverage group*” shall mean a category of members who meet certain common eligibility requirements.

“Covered services” shall mean mental health and substance abuse treatment services reimbursable based on provisions of the Medicaid state plan and paid through the fee-for-service payment system administered by the Iowa Medicaid enterprise.

“Department” shall mean the Iowa department of human services acting in cooperation with the department of public health for governance of the contract.

“Designee” shall mean an organization, person, or group of persons designated by the director to act on behalf of the department in the review or evaluation of services provided through the Iowa Plan.

“Director” shall mean the director of the Iowa department of human services.

“Disenrollment” shall mean the removal of an enrollee from the contractor’s enrollment list either through loss of eligibility or some other cause.

“Emergency services” shall mean those services required to meet the needs of an enrollee who is experiencing an acute crisis of a level of severity requiring immediate treatment where a failure to treat could result in death, injury, or lasting harm to the enrollee or serious danger to others.

“Encounter data” shall mean information reflecting a face-to-face meeting or other billable service furnished by a provider to a person served through the Iowa Plan. Medicaid encounter data must be submitted by the contractor to the department in an electronic format specified by the department.

“Enrollee” shall mean any Medicaid member who is enrolled in the Iowa Plan in accordance with the provisions of the contract.

“Enrollment” shall mean the inclusion of a Medicaid member on a contractor’s Medicaid enrollment file.

“Enrollment area” shall mean the geographical area in which the enrollees that are assigned by the department to the contractor reside.

“Fee-for-service” shall mean the method of making payment for Medicaid services reimbursable under the Medicaid state plan in which reimbursement is based on fees set by the department for defined services. Payment of the fee is based upon delivery of the defined services and is done through the Iowa Medicaid enterprise.

“Grievance” shall mean a nonclinical incident, nonclinical complaint, or nonclinical concern which is received verbally and which cannot be resolved in a manner satisfactory to enrollees or participating or nonparticipating providers by the immediate response of the contractor’s staff member or a nonclinical incident, nonclinical complaint, or nonclinical concern which is received in writing.

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

“Integrated mental health services and supports” shall mean individualized mental health services and supports planned jointly by the contractor, the enrollee, and others significant to the enrollee as appropriate, which are not regularly defined services otherwise offered by the contractor.

“Iowa Plan” shall mean the Iowa Plan for Behavioral Health, established by this division as the managed care plan to provide mental health and substance abuse treatment.

“Licensed” shall mean a facility, equipment, individual or entity that has formally met state requirements for licensure and has been granted a license.

“Member” shall mean a person determined eligible for Medicaid.

“Mental health services” shall mean those clinical, rehabilitative, or supportive services provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any mental disorder listed in the International Classification of Diseases—Ninth Edition (ICD-9). At a minimum, covered disorders include the following ranges of the ICD-9: 290-302.9; 306-309.9; and 311-314.9. Additional code ranges may be included in the contract. Mental health services shall include, but not be limited to, those services listed at subrule 88.65(3).

“MHI” shall mean a state mental health institute operated by the department.

“Open panel” shall mean that the contractor shall subcontract with all providers who are appropriately licensed, certified, or accredited to provide covered, required, or optional services, and who meet the credentialing criteria, agree to the standard contract terms, and wish to participate.

“Participating providers” shall mean the providers of mental health and substance abuse services who subcontract with the contractor.

“Prepaid health plan (PHP)” shall mean an entity defined at Section 1903(m)(2)(B)(iii) of the Social Security Act and determined to be a PHP by the department based upon criteria set forth in the Code of Federal Regulations at Title 42, Part 434.20(a)(3), as amended to March 13, 1991.

“Prior authorization” shall mean the process by which an enrollee or a provider obtains approval prior to the initiation or continuation of a service as to the appropriateness of a service. The contractor may require prior authorization as a condition of payment. Prior authorization of a mental health service shall be based on psychosocial necessity. Prior authorization of a substance abuse service shall be based on service necessity.

“Psychosocial necessity” shall mean that clinical, rehabilitative, or supportive mental health services meet all of the following conditions. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered mental health diagnosis.
2. Provided for the diagnosis or direct care and treatment of a mental disorder.
3. Within standards of good practice for mental health treatment.
4. Required to meet the mental health needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

The determination of psychosocial necessity shall be made after consideration of the enrollee’s clinical history, including the impact of previous treatment and service interventions; services being provided concurrently by other delivery systems; the potential for services and supports to avert the need for more intensive treatment; the potential for services and supports to allow the enrollee to maintain functioning improvement attained through previous treatment; unique circumstances which may impact the accessibility or appropriateness of particular services for an individual enrollee (e.g., availability of transportation, lack of natural supports including a place to live); and the enrollee’s choice of provider or treatment location.

“Required services” shall mean mental health and substance abuse treatment services and supports which are not reimbursable through the Iowa Medicaid fee-for-service program but which are the contractual responsibility of the contractor.

“Retroactive eligibility” shall mean the period of time consisting of the three months preceding the month in which an application for Medicaid is filed, during which the person may be eligible for Medicaid coverage as determined by the department.

“Routine care” shall mean those clinical, rehabilitative, or supportive mental health or substance abuse services which are typically arranged through regular, scheduled appointments with a provider. Conditions requiring routine care are not likely to substantially worsen or cause damage or disruption to the recipient’s life without immediate intervention.

“Service necessity” shall mean that substance abuse services for the treatment of conditions related to substance abuse meet the following requirements according to the criteria of the ASAM-PPC-2R. The services shall be:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a covered substance abuse diagnosis.
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder.
3. Within standards of good practice for substance abuse treatment.
4. Required to meet the substance abuse treatment needs of the enrollee and not primarily for the convenience of the enrollee, the provider, or the contractor.
5. The most appropriate type of service which would reasonably meet the needs of the enrollee in the least costly manner.

“Substance abuse licensed PMIC” shall mean a psychiatric medical institution for children (PMIC) which also is licensed in accordance with Iowa Code chapter 125 to provide substance abuse treatment services.

“Substance abuse services” shall mean those clinical, rehabilitative, supportive and other services provided in response to and to alleviate the symptoms of any substance abuse disorder listed in the

International Classification of Diseases—Ninth Edition (ICD-9), disorders 303 through 305.9, provided by an individual, agency, or other entity that is licensed, accredited, certified, or otherwise approved as required by law to treat any of these substance abuse disorders. Services include, but are not limited to, services listed at subrule 88.65(4).

“*Targeted case management services*” shall mean MR/CMI/DD case management services targeted to adults with a primary diagnosis of chronic mental illness as defined at rule 441—90.1(249A), with standards set forth in 441—Chapter 24 and Medicaid requirements set forth in 441—Chapter 90.

“*Third party*” shall mean an individual, entity, or program, excluding Medicaid, that is, may be, could be, should be, or has been liable for all or part of the cost of mental health and substance abuse services related to any medical assistance covered by Medicaid.

“*Urgent, nonemergency care*” shall mean those clinical, rehabilitative, or supportive services provided for conditions which, although they do not present immediate risk of death, injury, or lasting harm, may risk significant damage or disruption to the recipient’s life or require expeditious treatment to alleviate the prospect that the condition will substantially worsen without immediate intervention.

441—88.62(249A) Participation.

88.62(1) Contract. The department may enter into a contract for the provision of mental health and substance abuse services specified in 441—Chapter 78, or any portion thereof, with a prepaid health plan.

a. The department shall also determine that the contractor meet the following additional requirements:

(1) The contractor shall make the services it provides to enrollees at least as accessible as those services were to members prior to the implementation of the Iowa Plan.

(2) The contractor shall comply with insolvency requirements established by the department in the contract and shall ensure that neither Medicaid enrollees nor the state shall be responsible for its debts if the contractor should become insolvent.

(3) The contractor shall be licensed by the department of commerce, division of insurance, as a limited service organization.

b. The contract shall meet the following minimum requirements. The contract shall:

(1) Be in writing.

(2) Specify the duration of the contract period.

(3) List the services which must and may be covered.

(4) Describe information access and disclosure.

(5) List conditions for nonrenewal, termination, suspension, and modification.

(6) Specify the method and rate of reimbursement.

(7) Provide for disclosure of ownership and subcontractor relationships.

(8) Specify that all subcontracts shall be in writing, shall comply with the provisions of the contract between the department and the contractor, and shall include any general requirements of the contract that are appropriate to the service or activity covered by the subcontract.

88.62(2) Assessment of penalties. Penalties shall be assessed according to terms of the contract for failure to perform in either of the following areas:

a. Substantial failure to provide necessary covered and required services included in this contract when the failure has seriously and adversely affected an enrollee.

b. Failure to comply with any provision of the contract.

441—88.63(249A) Enrollment.

88.63(1) Enrollment area. The enrollment area shall be set forth in the contract between the department and the contractor. The department has determined that all counties of the state will be covered by the Iowa Plan, whether by a single statewide contractor or by multiple regional contractors.

88.63(2) Members subject to enrollment. All Medicaid members shall be subject to mandatory enrollment in the Iowa Plan.

a. Members who are enrolled in the Iowa Plan are notified of enrollment and the effective date of the enrollment.

b. When a coverage group is included in or excluded from Iowa Plan enrollment, the department and the contractor shall jointly notify members and participating and nonparticipating Medicaid providers before implementation of the change. The department shall implement a transition plan to ensure continuity of services to members.

88.63(3) *Others to be served.* The department may include other recipients of mental health and substance abuse services in the Iowa Plan. The department shall specify in the contract the services, persons to be served, and reimbursement methodology when other recipients are included.

88.63(4) *Voluntary enrollment.* There will be no voluntary enrollment in the Iowa Plan.

88.63(5) *Effective date.* For new members, the effective date of enrollment with the contractor shall be the first day of the month the Medicaid application was filed in the county office. Members under the age of 21 served at an MHI and members served at a substance abuse licensed PMIC will be enrolled for months of retroactive eligibility for Medicaid when the member resided in a substance abuse licensed PMIC or MHI during those months.

For current members who are no longer in an eligibility group excluded from the Iowa Plan, the effective date of enrollment shall be the first day of the month following the month they leave the excluded group.

88.63(6) *Medical card.* The department shall issue Form 470-1911, Medical Assistance Eligibility Card, to each member. Before delivering mental health or substance abuse services, the provider shall access the department's eligibility verification system (ELVS) to verify the member's enrollment in the Iowa Plan.

441—88.64(249A) Disenrollment.

88.64(1) *Disenrollments by the department.* Disenrollments shall occur when:

a. The enrollee becomes ineligible for Medicaid. If the enrollee becomes ineligible and is later reinstated to Medicaid, enrollment in the Iowa Plan shall also be reinstated.

b. The enrollee is transferred to a coverage group excluded from the Iowa Plan.

c. The enrollee dies.

88.64(2) *Effective date.* Disenrollment shall be effective the first day of the month following the month of disenrollment.

88.64(3) *No disenrollment for health reasons.* No enrollee shall be disenrolled from the Iowa Plan because of an adverse change in health status, including mental health and substance abuse status.

441—88.65(249A) Covered services.

88.65(1) *Amount, duration, and scope of services.* The contractor may not impose limitations on the amount, duration, or scope of services provided which are not allowable under the Medicaid state plan. The contractor may, however, require the use of participating providers, require prior authorization for services other than emergency services as set forth in rule 441—88.66(249A), and direct enrollees to the appropriate level of care for receipt of those services which are the responsibility of the contractor.

88.65(2) *Enrollee use of Iowa Plan services.* Enrollees shall receive all Medicaid-funded covered, required, and optional mental health and substance abuse services only through the Iowa Plan. An enrollee shall use only participating providers of service unless the contractor has authorized a referral to a nonparticipating provider for provision of a service or treatment plan. Payment shall be denied under Medicaid fee-for-service on claims for covered, required, and optional mental health and substance abuse services provided to enrollees. The contractor shall implement policies to ensure that no participating or nonparticipating provider bills an enrollee for all or any part of the cost of a covered, required, or optional service.

88.65(3) *Covered, required and optional mental health services.*

a. The contractor shall ensure, arrange, monitor and reimburse, at a minimum, the following covered mental health services:

(1) Ambulance services for psychiatric conditions.

- (2) Emergency room services for psychiatric conditions available 24 hours per day, 365 days per year.
- (3) Inpatient hospital care for psychiatric conditions.
- (4) Outpatient hospital care for psychiatric conditions including intensive outpatient services.
- (5) Partial hospitalization.
- (6) Day treatment.
- (7) Psychiatric physician services including consultations requested for enrollees receiving treatment for other medical conditions.
- (8) Services of a licensed psychologist for testing, evaluation and treatment of mental illness.
- (9) Services in state MHIs for enrollees under the age of 21 or through the age of 22 if the enrollee is hospitalized on the enrollee's twenty-first birthday.
- (10) Services provided through a community mental health center.
- (11) Targeted case management services to persons with chronic mental illness.
- (12) Medication management.
- (13) Psychiatric nursing services by a home health agency.
- (14) Psychiatric or psychological screenings required subsequent to evaluations for persons applying for admission to nursing homes.
- (15) Mental health services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.
- (16) Behavioral health intervention as set forth in rule 441—78.12(249A).
- (17) Inpatient psychiatric services in psychiatric medical institutions for children as set forth in 441—Chapter 85, Division II.

b. The contractor shall ensure, arrange, monitor and reimburse the following required mental health services which are not reimbursable by Medicaid fee-for-service:

- (1) Concurrent substance abuse and mental health services for those diagnosed with both chronic substance abuse and chronic mental illness.
- (2) Services of a licensed social worker for treatment of mental illness.
- (3) Mobile crisis services.
- (4) Mobile counseling services.
- (5) Integrated mental health services and supports.
- (6) Psychiatric rehabilitation services.
- (7) Peer support services for persons with chronic mental illness.
- (8) Community support services.
- (9) Periodic assessment of the level of functioning for each enrollee who meets the criteria of either a child with a serious emotional disability or a person with serious and persistent mental illness. The assessment is to be conducted by appropriately credentialed participating providers.
- (10) Programs of assertive community treatment.

c. The contractor may develop optional services and supports to address the mental health needs of enrollees. These optional services and supports shall be implemented only after approval by the department. Optional services and supports shall be provided by or under the supervision of qualified mental health professionals or appropriately accredited agencies.

d. The department may require the coverage of other mental health services and supports under the terms of the contract.

88.65(4) *Covered and required substance abuse services.* The contractor shall ensure, arrange, monitor and reimburse the following services for the treatment of substance abuse:

- a.* Outpatient services (all Level I services according to the ASAM-PPC-2R).
- b.* Intensive outpatient and partial hospitalization services (all Level II services according to the ASAM-PPC-2R).
- c.* Residential or inpatient services (all Level III services according to the ASAM-PPC-2R).
- d.* Medically managed intensive inpatient services (all Level IV services according to the ASAM-PPC-2R).
- e.* Detoxification.

- f.* PMIC substance abuse treatment services.
- g.* Emergency room services for substance abuse conditions available 24 hours a day, 365 days a year.
- h.* Ambulance services for substance abuse conditions.
- i.* Substance abuse treatment services determined necessary subsequent to an EPSDT screening meeting the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requirements.
- j.* Intake, assessment, evaluation and diagnostic services, including testing for alcohol and drugs, to determine a substance abuse diagnosis.

88.65(5) Covered diagnoses. Services for a covered diagnosis cannot be denied solely on the basis of an individual's also having a noncovered diagnosis. Mental health services, including inpatient care, cannot be denied solely on the basis of an individual's having no Axis I diagnosis. The contractor will be responsible for ensuring, arranging, monitoring, and reimbursing services necessary for the behavioral care and treatment of the covered diagnoses for Iowa Plan enrollees who are diagnosed with a covered diagnosis and a noncovered diagnosis.

The services defined at subrules 88.65(3) and 88.65(4) shall be provided to all Iowa Plan enrollees who meet the diagnostic criteria for the following disorders listed in the International Classification of Diseases—Ninth Edition (ICD-9):

1. Mental health: 290-302.9; 306-309.9; 311-314.9.
2. Substance abuse: 303-305.9.

88.65(6) Excluded services. Unless the service is specifically included in the contract, the contractor shall not be required to provide long-term care (e.g., residential care facilities, nursing facilities, state resource centers, or intermediate care facilities for persons with mental retardation) services.

[ARC 9487B, IAB 5/4/11, effective 7/1/11; ARC 0191C, IAB 7/11/12, effective 7/1/12]

441—88.66(249A) Emergency services.

88.66(1) Availability of services. The contractor shall ensure that emergency services for covered diagnoses are available 24 hours a day, seven days a week, either through participating providers or through arrangements with other providers.

88.66(2) Payment for emergency room services. Emergency room services for covered diagnoses shall be reimbursed for enrollees regardless of whether authorized in advance or whether the provider of service is a participating provider.

a. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor may:

- (1) Establish policies requiring notification of the provision of emergency room service within a stated time frame which shall be no less than 48 hours.
- (2) Require authorization of any services beyond those provided in the emergency room.

b. For emergency room services provided to an Iowa Plan enrollee by a participating or a nonparticipating provider when covered diagnoses are the primary condition, the contractor shall:

(1) Provide a minimum triage fee to the emergency room, regardless of whether the facility notifies the contractor. The triage fee shall be no less than is paid under payment mechanisms established for the Medicaid fee-for-service program.

(2) Reimburse the emergency room for emergency room services provided, contingent upon the facility's compliance with notification policies. Reimbursement to nonparticipating providers shall be no less than the average payment which would be made to a participating provider.

88.66(3) Contractor payment liability. The contractor's payment liability for the provision of emergency mental health and substance abuse services by nonparticipating providers is limited to emergency mental health and substance abuse services provided before the enrollee can, without danger or harmful consequences to the enrollee or others, return to the care of a participating provider. If transportation is necessary to transport the enrollee from a nonparticipating provider to a participating provider, the contractor shall be financially liable for the transportation. In reimbursing nonparticipating providers, the contractor's liability is limited to the average reimbursement which the contractor would pay to a participating provider for the same services.

88.66(4) Notification and claim filing time spans. The contractor may set notification and claim filing time limitations in the event of the provision of care by nonparticipating providers and shall notify enrollees of these provisions. However, failure to give notice or to file claims within those time limitations shall not invalidate any claim if it can be shown that it was not reasonably possible to give the notice and that notice was, in fact, given as soon as was reasonably possible. In addition, the contractor shall provide payment for emergency services to nonparticipating providers within 60 days of receipt of a bill which complies with all billing requirements established by the contractor's policies.

441—88.67(249A) Access to service.

88.67(1) Choice of provider. Enrollees shall have the opportunity to choose their mental health care and substance abuse treatment professionals and service providers from any of the participating providers to the extent clinically appropriate.

88.67(2) Open panel requirement. The contractor shall establish and implement policies to ensure an open panel approach to the recruitment of participating providers.

88.67(3) Requirements for participating provider panel. The contractor shall develop and maintain a panel of participating providers which meets the following requirements. The panel shall:

a. Have sufficient staff resources to adequately provide mental health and substance abuse services to meet the needs of enrollees or have arrangements for services to be provided by other providers where capability of participating providers to serve specific mental health and substance abuse needs does not exist.

b. Maintain treatment sites in compliance with all applicable local, state, and federal standards related to the services provided as well as those for fire and safety.

88.67(4) Adequate appointment system. The contractor shall require that participating providers have procedures for the scheduling of enrollee appointments, which are appropriate to the reason for the service, as follows:

a. Enrollees with emergency needs shall be seen within 15 minutes of presentation at a service delivery site.

b. Persons with urgent nonemergency needs shall be seen within 1 hour of presentation at a service delivery site or within 24 hours of telephone contact with provider or contractor.

c. Persons with persistent symptoms shall be seen within 48 hours of reporting symptoms.

d. Persons with need for routine services shall be seen within three weeks of the request for appointment.

88.67(5) Adequate after-hours call-in coverage. The contractor shall ensure crisis counseling and referral are available 24 hours a day, 365 days per year via a toll-free telephone line, the number for which is regularly made available to all enrollees.

88.67(6) Adequate referral system. The contractor shall have in effect arrangements which provide for an adequate referral system for any specialty mental health and substance abuse treatment services not available through participating providers.

88.67(7) Discharge planning. The contractor shall implement policies to ensure that no enrollee who has been receiving services in a 24-hour setting funded by the contractor is discharged from that setting until a discharge plan has been developed which provides appropriate follow-up care and treatment which is accessible to that enrollee.

88.67(8) Lack of discharge plan. When a discharge plan as described in subrule 88.67(7) has not been developed or cannot be implemented, the following shall apply:

a. If the contractor is not required to pay for services at the 24-hour level of care as set forth in subrule 88.73(2) because the services do not meet the criteria of psychosocial necessity or service necessity, the contractor is required (keep kids safe policy) to authorize up to 14 calendar days of additional funding on an administrative basis for enrollees under the age of 18 if a safe and appropriate living arrangement is not available because:

(1) A court order is in effect that must be modified to allow the placement of the child into that living arrangement;

(2) A court order is required to allow placement of the child into the appropriate living arrangement;

(3) A bed is not available in the level of care which has been determined as clinically appropriate for the child; or

(4) Services and support must be arranged to assist the natural family, foster family, or other living arrangement to become ready to assist the enrollee after the enrollee's return to that environment.

b. If 24-hour services provided through the Iowa Plan are being decertified, payment is limited in accordance with subrule 88.73(2) except as provided in paragraph 88.67(8) "a."

441—88.68(249A) Review of contractor decisions and actions.

88.68(1) *Clinical decision review.* The contractor shall have written procedures by which enrollees and participating and nonparticipating providers may request a clinical decision review. The clinical decision review, when requested, shall be conducted by staff other than the person or persons who made the original clinical care decision. All policies related to clinical decision review shall be approved by the department prior to implementation. The contractor's clinical decision review policies shall further:

a. Require acknowledgment of the receipt of a request for a clinical decision review to the enrollee and to the provider if applicable within three working days.

b. Allow for participation by the enrollee and the provider.

c. Set time frames for resolution including emergency procedures which are appropriate to the nature of the clinical decision under review.

d. Require that 95 percent of all clinical decision reviews be resolved within 14 days of receipt of all required documentation and that 100 percent of all clinical decision reviews be resolved within 90 days of the receipt of all required documentation.

e. Ensure the participation of contractor staff with authority to require corrective action.

f. Include at least one level of internal review.

g. Ensure the confidentiality of the enrollee.

88.68(2) *Appeal to department.* Enrollees may appeal clinical care decisions in accordance with the appeal process available to all persons receiving Medicaid-funded services as set forth in 441—Chapter 7 if the enrollee is not satisfied with the final decision rendered by the contractor through the contractor's clinical decision review process.

88.68(3) *Review of nonclinical decisions.* The contractor shall have available to all enrollees and other persons who do business with the contractor a process for the review of any complaints or grievances concerning nonclinical matters. All policies related to the review of nonclinical decisions shall be approved by the department prior to implementation. Policies regarding the process for the review of nonclinical decisions shall incorporate the following:

a. Allow initiation both verbally and in writing.

b. Require a review conducted by someone other than the person who made the original decision.

c. Require written notice acknowledging the receipt of a complaint or grievance.

d. Require resolution of 95 percent of all complaints or grievances within 14 days of the receipt of all required documentation and resolution of 100 percent within 90 days of the receipt of all required documentation.

88.68(4) *Written record.* All requests for review of contractor decisions and actions, including all informal or verbal complaints which must be referred or researched for resolution, shall be recorded in writing. A log shall be retained and made available at the request of the department. The log shall include progress notes and method of resolution to allow determination of compliance with subrules 88.68(1) and 88.68(3).

88.68(5) *Information concerning procedures relating to the review of contractor decisions and actions.* The contractor's written procedures for the review of contractor decisions and actions shall be provided to each new enrollee, to participating providers in a provider manual, and to nonparticipating providers upon request.

88.68(6) *Periodic reports to the department.* The contractor shall make reports to the department summarizing the review of contractor decisions and actions and resolutions to the reviews at a frequency specified in the contract.

441—88.69(249A) Records and reports.

88.69(1) *Records system.* The contractor shall document and maintain clinical and fiscal records throughout the course of the contract. The record system shall:

- a. Identify transactions with or on behalf of each enrollee by the state identification number assigned to the enrollee by the department.
- b. Provide a rationale for and documentation of clinical care decisions made by the contractor based upon psychosocial necessity for mental health services and service necessity for substance abuse services.
- c. Permit effective professional review for medical audit processes.
- d. Facilitate an adequate system for monitoring treatment reimbursed by the contractor including follow-up of the implementation of discharge plans and referral to other providers.
- e. Meet contract reporting requirements and federal reporting requirements applicable to prepaid health plans.

88.69(2) *Content of individual treatment record.* The contractor shall have contractual requirements with participating providers which ensure an adequate record-keeping system, including documentation of all Iowa Plan services provided to each enrollee, in compliance with the provisions of rule 441—79.3(249A).

88.69(3) *Confidentiality of mental health information.* The contractor shall protect and maintain the confidentiality of mental health information by implementing policies for staff and through contract terms with participating providers which allow release of mental health information only as allowed by Iowa Code chapter 228.

88.69(4) *Confidentiality of substance abuse information.* The contractor shall protect and maintain the confidentiality of substance abuse information by implementing policies for staff and through contract terms with participating providers which allow release of substance abuse information only in compliance with policies set forth in the Code of Federal Regulations at Title 42, Part 2, as amended to May 5, 1995, and other applicable state and federal law and regulations.

88.69(5) *Reports to the department.* The contractor shall submit reports to the department as follows:

- a. Encounter data on a monthly basis.
- b. Annual audited financial statements no later than 180 days after the close of each contract year.
- c. Periodic financial, utilization, and statistical reports as required by the department in the contract.

- d. Other reporting requirements as specified in the contract.

88.69(6) *Audits.* The department or its designee and the U.S. Department of Health and Human Services (HHS) may evaluate through inspections or other means the quality, appropriateness, and timeliness of services performed by the contractor, participating providers, nonparticipating providers, and subcontractors pertaining to services performed and reimbursed under the contract. The department or its designee or HHS may audit and inspect any records of the contractor, participating providers, nonparticipating providers and subcontractors of the contractor, pertaining to services performed and the determination of amounts paid under the contract. These records shall be made available at times, places, and in a manner as authorized representatives of the department, its designee, or HHS may request.

441—88.70(249A) Marketing. The marketing of Iowa Plan services is prohibited.

441—88.71(249A) Enrollee education.

88.71(1) *Use of services.* The contractor shall provide written information to all enrollees on the use of services the contractor is responsible to ensure, arrange, monitor, and reimburse. Information must include services covered; how to access services; providers participating; explanation of the process for the review of contractor decisions and actions, including the enrollee's right to a fair hearing under 441—Chapter 7 and how to access that fair hearing process; provision of after-hours and emergency care; procedures for notifying enrollees of a change in benefits or office sites; how to request a change in providers; statement of consumer rights and responsibilities; out-of-area use of service; availability

of toll-free telephone information and crisis assistance; appropriate use of the referral system; and the method of accessing Medicaid-funded services not covered by the Iowa Plan, especially pharmacy services.

88.71(2) *Outreach to members with special needs.* The contractor shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, mental retardation or other cognitive impairments, homeless persons, illiterate persons, non-English-speaking persons and persons with visual or hearing impairments.

88.71(3) *Patient rights and responsibilities.* The contractor shall have in effect a written statement of patient rights and responsibilities which is available upon request as well as issued to all new enrollees. This statement shall be part of enrollment information provided to all new enrollees.

441—88.72(249A) Payment to the contractor.

88.72(1) *Capitation rate.* In consideration for all services rendered by the contractor under a Medicaid contract with the department, the contractor shall receive a payment each month for each enrollee. This Medicaid capitation rate represents the total obligation of the department with respect to the costs of Medicaid mental health and substance abuse services provided to enrollees under the contract. The contractor accepts the rate as payment in full for the Medicaid-contracted services.

88.72(2) *Determination of rate.* The Medicaid capitation rates shall be established in the contract and shall not exceed the cost to the department of providing the same covered services on a fee-for-service basis to the same group of Medicaid members eligible for the plan.

88.72(3) *Payment for services to other recipients.* When the department chooses to include mental or substance abuse services for recipients other than enrollees, the department shall establish rates and reimbursement procedures in the contract.

88.72(4) *Third-party liability.* If an enrollee has health coverage or a responsible party other than the Medicaid program available for purposes of payment for mental health and substance abuse expenses, it is the right and responsibility of the contractor to investigate these third-party resources and attempt to obtain payment. The contractor may retain all funds collected through third-party sources. A complete record of third-party liability shall be maintained and made available to the department at the end of each contract year.

441—88.73(249A) Claims payment.

88.73(1) *Claims payment by contractor.* The contractor shall meet the following time lines for the payment of all claims for covered, required and optional mental health and substance abuse services submitted which meet the contractor's requirements for claim submission:

a. For at least 85 percent of claims submitted, payment shall be mailed or claims shall be denied within 14 days of the date the claim is received by the contractor.

b. For at least 90 percent of claims submitted, payment shall be mailed or claims shall be denied within 30 days of the date the claim is received by the contractor.

c. For 100 percent of claims submitted, payment shall be mailed or claims shall be denied within 90 days of the date the claim is received by the contractor.

88.73(2) *Limits on payment responsibility for services.*

a. The contractor is not required to reimburse providers for the provision of mental health services that do not meet the criteria of psychosocial necessity.

b. The contractor is not required to reimburse providers for the provision of substance abuse services that do not meet the criteria of service necessity.

c. The contractor is not required to reimburse providers for the provision of MR/CMI/DD case management services that do not meet the criteria and requirements set forth in 441—Chapter 90.

d. The contractor has the right to require prior authorization of covered, required and optional services and to deny reimbursement to providers who do not comply with such requirements.

e. Payment responsibilities for emergency room services are as provided at subrule 88.66(2).

f. Payment responsibility for services provided under the “keep kids safe” policy is set forth at subrule 88.67(8).

88.73(3) *Payment to nonparticipating providers.* In reimbursing nonparticipating providers, the contractor is obligated to pay no more than the average rate of reimbursement which the contractor pays to participating providers for the same service.

88.73(4) *Payment of crossover and copayments.* Rescinded IAB 1/9/02, effective 3/1/02.

441—88.74(249A) *Quality assurance.* The contractor shall have in effect an internal quality assurance system which meets the requirements of 42 CFR, Part 434.34 as amended to March 12, 1984, and complies with all other requirements specified in the contract.

441—88.75(249A) *Iowa Plan advisory committee.* The department shall appoint an advisory committee to advise the department in the implementation and operation of the Plan and to provide for ongoing public input in its operation.

441—88.76 to 88.80 Reserved.

DIVISION V
PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY

441—88.81(249A) *Scope and definitions.*

88.81(1) *Purpose.* A program of all-inclusive care for the elderly (PACE) organization provides prepaid, capitated, comprehensive health care services designed to meet the following objectives:

- a. Enhance the quality of life and autonomy of frail older adults.
- b. Maximize the dignity of and respect for frail older adults.
- c. Enable frail older adults to live in the community as long as medically and socially feasible.
- d. Preserve and support frail older adults' family units.

88.81(2) *Scope.* PACE programs may serve Medicaid members, Medicare beneficiaries, persons eligible for both Medicare and Medicaid benefits, and private-pay individuals. Enrollment to receive services from a PACE organization is voluntary.

a. Enrollment is limited to persons who are 55 years of age or older and who need care at the nursing facility level but are able to live in a community setting without jeopardizing their health and safety.

b. If a Medicaid member chooses to enroll in a PACE program, the member must receive Medicaid benefits solely through the PACE organization while enrolled in the program.

88.81(3) *Authorization.* A PACE organization must enter into a three-way agreement with the department and the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

88.81(4) *Definitions.* For purposes of this division:

"Alternate PACE service site" means a location outside a primary or alternate PACE center in which one or more PACE services are offered to PACE enrollees.

"Capitation rate" means the monthly fee the department pays to a PACE organization for each Medicaid enrollee for the provision of covered medical and health services, whether or not the enrollee received services during the month for which the fee is intended.

"CMS" means the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

"Contract year" means the term of a PACE program agreement. The term is a calendar year, with the exception that a PACE organization's initial contract year is determined by CMS and may be from 12 to 23 months.

"Department" means the Iowa department of human services.

"Enrollee" means a person who is enrolled in a PACE program.

"Federal PACE regulations" means the standards published in 42 CFR Part 460, Programs of All-Inclusive Care for the Elderly. These rules shall be interpreted so as to comply with the federal PACE regulations.

“*Interdisciplinary team*” means the team designated by the PACE organization to assess the needs of and develop a comprehensive plan of care for each enrollee.

“*Medicaid enrollee*” means a Medicaid member who is enrolled in a PACE program.

“*Medicare beneficiary*” means a person who is entitled to Medicare Part A benefits, is enrolled under Medicare Part B, or both.

“*Medicare enrollee*” means a Medicare beneficiary who is enrolled in a PACE program.

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

“*PACE center*” means a facility operated by a PACE organization where primary care is furnished to PACE enrollees. A primary PACE center is the principal facility operated by a PACE organization. An alternate PACE center is another facility operated by a PACE organization outside its primary center. “Primary care” shall include all program components in accordance with 42 CFR Section 460.92 as amended to December 8, 2006.

“*PACE enrollment agreement*” means the contract between the PACE organization and the enrollee that includes, at a minimum, all information identified in 42 CFR Section 460.154 as amended to December 8, 2006.

“*PACE organization*” means an entity that has in effect a PACE program agreement with the department and CMS to operate a PACE program in Iowa.

“*PACE program*” means a program of all-inclusive care for the elderly operated by an approved PACE organization that provides comprehensive health care services to enrollees in Iowa in accordance with a PACE program agreement.

“*PACE program agreement*” means a three-way agreement between CMS, the department, and an entity approved to be a PACE organization for the operation of a PACE program.

“*Service area*” means the specific counties in which a PACE provider may provide services, as identified in the PACE program agreement.

“*Services*” means both items and services provided to an enrollee by the PACE organization.

“*Trial period*” means the first three contract years in which a PACE organization operates under a PACE program agreement.

441—88.82(249A) PACE organization application and waiver process. This rule sets forth the application requirements for an entity that seeks approval from the department as a PACE organization and the process by which a prospective PACE organization may request department review and approval of requests to CMS for waiver of federal requirements.

88.82(1) Application requirements. A person authorized to act on behalf of an entity seeking approval as a PACE organization shall prepare an application in the format suggested by CMS at: http://www.cms.hhs.gov/PACE/06_ProviderApplicationandRelatedResources.asp.

a. The application shall:

(1) Describe how the entity meets the requirements of this division and of the federal PACE regulations; and

(2) Identify the counties in which the entity proposes to provide PACE services.

b. Upon completion of the application sections designated for PACE providers, the prospective PACE organization shall submit the application to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(2) Waiver of federal requirements. A prospective PACE organization must also receive CMS approval as a PACE organization. A prospective PACE organization must submit any request for waiver of federal PACE regulations to the department for initial review before submitting the request to CMS.

a. The waiver request shall be submitted as a document separate from the application. The request may be submitted:

(1) In conjunction with and at the same time as the application; or

(2) At any time during the approval process.

b. The prospective PACE organization shall submit the waiver request and documentation to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

88.82(3) *Review of applications and requests for waiver of federal requirements.* The department may conduct on-site visits and may request additional information from an entity in connection with an application for approval as a PACE organization or a request for waiver of federal requirements.

88.82(4) *Department action on applications.* Upon review of an application for approval as a PACE organization and action by CMS on any request for waiver of federal requirements, the department shall determine whether it considers the entity qualified to be a PACE organization and whether it is willing to enter into a PACE program agreement with the entity. If so, the department shall complete the application sections designated for the state administering agency and submit the completed application in its entirety to CMS.

441—88.83(249A) PACE program agreement. An entity that has been approved by the department and CMS to be a PACE organization must enter into an agreement with CMS and the department for the operation of a PACE program under Medicare and Medicaid. The agreement must be signed by an authorized official of CMS, the PACE organization, and the department.

88.83(1) *Content and terms of agreement.*

a. Required content. A PACE program agreement must include the following information:

(1) A designation of the service area of the PACE organization's program, identified by county. The department and CMS must approve any change in the designated service area.

(2) The PACE organization's commitment to meet all applicable requirements under federal, state, and local laws and regulations, including provisions of the Civil Rights Act, the Age Discrimination Act, and the Americans with Disabilities Act.

(3) The effective date and term of the agreement.

(4) A description of the organizational structure of the PACE organization and information on the organization's administrative contacts.

(5) An enrollee bill of rights approved by CMS and an assurance that the listed rights and protections will be provided.

(6) A description of the process for handling enrollee grievances and appeals.

(7) A statement of the PACE organization's policies on eligibility, enrollment, voluntary disenrollment, and involuntary disenrollment.

(8) A description of the services available to enrollees.

(9) A description of the PACE organization's quality assessment and performance improvement program.

(10) A statement of the levels of performance required in CMS standard quality measures.

(11) A statement of the data and information required by the department and CMS to be collected on enrollee care.

(12) The Medicaid capitation rate and the methodology used to calculate the Medicare capitation rate.

(13) A description of procedures that the PACE organization will follow if the PACE program agreement is terminated, including how the organization will:

1. Inform enrollees, the community, CMS, and the department, in writing, about the organization's termination and transition procedures.

2. Initiate contact with income maintenance staff in the local department office and assist enrollees in obtaining reinstatement of conventional Medicare and Medicaid benefits.

3. Transition enrollees' care to other providers.

4. Terminate marketing and enrollment activities.

b. Optional content. An agreement may:

(1) Provide additional requirements for individuals to qualify as PACE enrollees in accordance with subparagraph 88.84(1)"a"(5).

(2) Contain any additional terms and conditions agreed to by the parties.

88.83(2) *Duration of agreement.* A PACE program agreement shall be effective for a contract year but may be extended for additional contract years in the absence of a notice by a party to terminate.

88.83(3) Enforcement of agreement. If the department determines that the PACE organization is not in substantial compliance with requirements of the federal PACE regulations or of this division, the department may take one or more of the following actions:

- a. Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.
- b. Withhold some or all payments under the PACE program agreement until the PACE organization corrects the deficiency.
- c. Terminate the PACE program agreement.

88.83(4) Termination of agreement by the department.

a. *Grounds for termination.* The department may terminate a PACE program agreement at any time for cause, including but not limited to the following circumstances:

(1) Termination due to uncorrected deficiencies. The department may terminate a PACE program agreement if both of the following circumstances exist:

1. The department has determined through a review pursuant to subrule 88.87(4) that the PACE organization has significant deficiencies in the quality of care furnished to enrollees or has failed to comply substantially with the conditions for a PACE organization or PACE program under this division, the federal PACE regulations, or the terms of its PACE program agreement.

2. The PACE organization has failed to develop and successfully initiate a plan to correct the deficiencies within 30 days of the date of receipt of a written notice of deficiencies, as confirmed by certified mail, or has failed to continue implementation of the corrective action plan.

(2) Termination due to health and safety risk. The department may terminate a PACE program agreement if the department determines that the PACE organization cannot ensure the health and safety of its enrollees. This determination may result from the identification of deficiencies that the department determines cannot be corrected.

b. *Notice and opportunity for hearing.* Except as provided in paragraph “c” of this subrule, before terminating an agreement, the department shall furnish the PACE organization with the following:

(1) A reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that are the basis of the department’s determination that cause exists for termination.

(2) Reasonable notice and opportunity for hearing (including the right to appeal an initial determination) before terminating the agreement.

c. *Immediate termination.* The department may terminate an agreement without invoking the procedures described in paragraph “b” of this subrule if the department determines that a delay in termination resulting from compliance with those procedures before termination would pose an imminent and serious risk to the health of the enrollees.

88.83(5) Termination of agreement by PACE organization. A PACE organization may terminate an agreement after timely notice issued as follows:

a. To CMS and the department, 90 days before termination.

b. To enrollees, 60 days before termination.

88.83(6) Transitional care during termination. A PACE organization whose PACE program agreement is being terminated must provide assistance to each enrollee in obtaining necessary transitional care by making appropriate referrals and making the enrollee’s medical records available to new providers.

441—88.84(249A) Enrollment and disenrollment. A PACE organization must comply with the federal enrollment requirements stated in 42 CFR Sections 460.152 through 460.156 as amended to December 8, 2006.

88.84(1) Eligibility for Medicaid enrollees. To enroll in a PACE program as an Iowa Medicaid enrollee, a person must meet the eligibility requirements specified in this subrule.

a. *Basic eligibility requirements.*

(1) The person must be 55 years of age or older.

(2) The person must reside in the service area of the PACE organization.

(3) The department must determine that the person is eligible for Iowa Medicaid pursuant to 441—Chapter 76.

(4) The department must determine that the person needs the nursing facility level of care.

(5) The person must meet any additional program-specific eligibility conditions imposed under the PACE program agreement. These additional conditions shall not modify the requirements stated in this subrule.

b. Other eligibility requirements.

(1) At the time of enrollment, the person must be able to live in a community setting without jeopardizing the person's health or safety, pursuant to the criteria specified in the PACE program agreement.

(2) To continue to be eligible for PACE as an Iowa Medicaid enrollee, a person must meet the annual recertification requirements specified in subrule 88.84(4).

88.84(2) *Effective date of enrollment.* A person's enrollment in the program is effective on the first day of the calendar month following the date the PACE organization receives the signed enrollment agreement.

88.84(3) *Duration of enrollment.* Enrollment continues until the enrollee's death unless either of the following actions occurs:

a. The enrollee voluntarily disenrolls. An enrollee may voluntarily disenroll from the program without cause at any time.

b. The enrollee is involuntarily disenrolled, as described in subrule 88.84(5).

88.84(4) *Annual recertification.*

a. At least annually, the department shall:

(1) Reevaluate whether each enrollee continues to need the nursing facility level of care; and

(2) Review all financial and nonfinancial eligibility requirements for Medicaid enrollees. The enrollee shall complete Form 470-3118 or 470-3118(S), Medicaid Review.

b. Deemed continued eligibility. If the department determines that an enrollee no longer needs the nursing facility level of care, the department, in consultation with the PACE organization, shall determine whether, in the absence of continued PACE coverage, the enrollee reasonably would be expected to meet the nursing facility level-of-care requirement within the next six months. This determination shall be based on a review of the enrollee's medical record and plan of care, applying criteria specified in the PACE program agreement. If the enrollee reasonably would be expected to meet the level-of-care requirement within six months, the enrollee's eligibility for the PACE program may continue until the next annual reevaluation.

88.84(5) *Involuntary disenrollment.* An involuntary disenrollment shall not become effective until the Department has determined that the PACE organization has adequately documented acceptable grounds for disenrollment.

a. Reasons for involuntary disenrollment. An enrollee may be involuntarily disenrolled for any of the following reasons:

(1) After a 30-day grace period, the enrollee fails to pay any amount due to the PACE organization pursuant to subrule 88.88(2) or refuses to make satisfactory arrangements to pay.

(2) The enrollee engages in disruptive or threatening behavior as described in paragraph 88.84(5) "b."

(3) The enrollee moves out of the PACE program service area or is out of the service area for more than 30 consecutive days, unless the PACE organization agrees to a longer absence due to extenuating circumstances.

(4) The department determines that the enrollee no longer needs the nursing facility level of care and the enrollee is not deemed eligible pursuant to paragraph 88.84(4) "b."

(5) The PACE program agreement with CMS and the department is not renewed or is terminated.

(6) The PACE organization is unable to offer health care services due to the loss of state licenses or contracts with outside providers.

b. Disruptive or threatening behavior. "Disruptive or threatening behavior" refers to either of the following:

- (1) Behavior that jeopardizes the enrollee's health or safety or the safety of others; or
- (2) Consistent refusal by the enrollee to comply with the enrollee's individual plan of care or the terms of the PACE enrollment agreement when the enrollee has decision-making capacity.

c. Documentation of disruptive or threatening behavior. If a PACE organization proposes to disenroll an enrollee who is disruptive or threatening, the organization must document the following information in the enrollee's medical record:

- (1) The reasons for proposing to disenroll the enrollee.
- (2) All efforts to remedy the situation.

d. Noncompliant behavior. A PACE organization may not disenroll an enrollee on the grounds that the enrollee has engaged in noncompliant behavior if the behavior is related to a mental or physical condition of the enrollee, unless the enrollee's behavior jeopardizes the enrollee's health or safety or the safety of others. "Noncompliant behavior" includes repeated noncompliance with medical advice and repeated failure to keep appointments.

88.84(6) *Effective date of disenrollment.*

a. In disenrolling a Medicaid enrollee, the PACE organization must:

- (1) Use the most expedient process allowed under the PACE program agreement;
- (2) Coordinate the disenrollment date between Medicare and Medicaid for an enrollee who is eligible for both Medicare and Medicaid; and
- (3) Give reasonable advance notice to the enrollee.

b. Until the date when enrollment is terminated, the following requirements must be met:

- (1) The PACE organization must continue to furnish all needed services.
- (2) The enrollee must continue to use PACE organization services.

88.84(7) *Documentation of disenrollment.* A PACE organization must meet the following requirements:

a. Have a procedure in place to document the reasons for all voluntary and involuntary disenrollments.

b. Make documentation available for review by CMS and the department.

c. Use the information on voluntary disenrollments in the PACE organization's internal quality assessment and performance improvement program.

88.84(8) *Reinstatement in other Medicare and medicaid programs.* After a disenrollment, the PACE organization shall work with CMS and the department to facilitate the former enrollee's reinstatement in other Medicare and Medicaid programs by:

a. Making appropriate referrals to other Medicare and Medicaid programs for which the enrollee may be eligible; and

b. Ensuring that medical records are made available to new providers in a timely manner.

88.84(9) *Reinstatement in PACE.* A previously disenrolled enrollee may be reinstated in a PACE program.

441—88.85(249A) Program services. A PACE organization shall furnish comprehensive medical, health, and social services that integrate acute and long-term care.

88.85(1) *Required services.* The PACE benefit package for all enrollees, regardless of the source of payment, must include the following:

a. All Medicare-covered items and services.

b. All Medicaid-covered items and services as specified in 441—Chapters 78, 81, 82, 85, and 90. Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost sharing do not apply to PACE services.

c. Other services determined necessary by the enrollee's interdisciplinary team to improve or maintain the enrollee's overall health status.

88.85(2) *Excluded services.* The following services are excluded from coverage under PACE:

a. Any service that is not authorized by the enrollee's interdisciplinary team, even if it is a required service, unless it is an emergency service.

b. In an inpatient facility:

- (1) A private room and private-duty nursing services unless medically necessary; and
- (2) Nonmedical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the interdisciplinary team as part of the enrollee's plan of care.

c. Cosmetic surgery. "Cosmetic surgery" does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

d. Experimental medical, surgical, or other health procedures.

e. Services furnished outside the United States, except in accordance with 42 CFR Sections 424.122 and 424.124 as amended to September 29, 1995, or as otherwise permitted under the Iowa Medicaid program.

88.85(3) Service delivery. The PACE organization must establish and implement a written plan to furnish care that meets the needs of each enrollee in all care settings 24 hours a day, every day of the year.

a. *Provision of services.* PACE services must be furnished in at least:

- (1) The PACE center,
- (2) The enrollee's home, and
- (3) Inpatient facilities.

b. *PACE center operation.* A PACE organization must ensure accessible and adequate services to meet the needs of its enrollees. The interdisciplinary team shall determine the frequency of each enrollee's attendance at a PACE center, based on the needs and preferences of the enrollee.

(1) A PACE organization must operate at least one PACE center either in or contiguous to its defined service area. A PACE center must be certified as an adult day services program pursuant to Iowa Code chapter 231D and the department of elder affairs' rules at 321—Chapter 24.

(2) If necessary to maintain sufficient capacity to allow routine attendance by enrollees, a PACE organization must add staff or develop alternate PACE centers or service sites. If a PACE organization operates more than one center, each alternate PACE center must offer the full range of services and have sufficient staff to meet the needs of enrollees.

88.85(4) Minimum services furnished at a PACE center. At a minimum, the following services must be furnished at each primary or alternate PACE center:

- a. Primary care, including physician and nursing services.
- b. Social services.
- c. Restorative therapies, including physical therapy and occupational therapy.
- d. Personal care and supportive services.
- e. Nutritional counseling.
- f. Recreational therapy.
- g. Meals.

88.85(5) Primary care. Primary medical care must be furnished to an enrollee by a PACE primary care physician. Each primary care physician is responsible for:

- a. Managing an enrollee's medical situations; and
- b. Overseeing an enrollee's use of medical specialists and inpatient care.

88.85(6) Out-of-network emergency care. A PACE organization must pay for out-of-network emergency care when the care is needed immediately because of an injury or sudden illness and the time required to reach the PACE organization or one of its contract providers would cause risk of permanent damage to the enrollee's health.

a. *Definitions.* As used in this subrule, the following definitions apply:

"*Emergency medical condition*" means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- 1. Serious jeopardy to the health of the enrollee.
- 2. Serious impairment to bodily functions of the enrollee.
- 3. Serious dysfunction of any bodily organ or part of the enrollee.

“Emergency services” means inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and are furnished by a qualified emergency services provider other than the PACE organization or one of its contract providers, either inside or outside the PACE organization’s service area.

“Poststabilization care” means services provided subsequent to an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized but that do not meet the definition of emergency services.

“Urgent care” means care that is provided to an enrollee outside the service area because the enrollee believes that an illness or injury is too severe to postpone treatment until the enrollee returns to the service area but that does not meet the definition of emergency services because the enrollee’s life or functioning is not in severe jeopardy.

b. Plan. A PACE organization must establish and maintain a written plan to handle out-of-network emergency care. The plan must ensure that CMS, the department, and the enrollee are held harmless if the PACE organization does not pay for out-of-network emergency services. The plan must provide for the following:

(1) An on-call provider available 24 hours per day to address enrollee questions about out-of-network emergency services and to respond to requests for authorization of out-of-network urgent care and poststabilization care following emergency services.

(2) Coverage of out-of-network urgent care and poststabilization care when either of the following conditions is met:

1. The PACE organization has approved the services.

2. The PACE organization has not approved the services because the PACE organization did not respond to a request for approval within one hour after being contacted or because the PACE organization cannot be contacted for approval.

c. Explanation to enrollee. The organization must ensure that the enrollee or caregiver, or both, understand:

(1) When and how to access out-of-network emergency services, and

(2) That no prior authorization is needed.

441—88.86(249A) Access to PACE services. An enrollee’s access to PACE services is governed by a comprehensive plan of care developed for each enrollee by an interdisciplinary team based on a comprehensive assessment of the enrollee’s health and social status.

88.86(1) Interdisciplinary team. A PACE organization shall establish an interdisciplinary team at each PACE center to comprehensively assess and meet the individual needs of each enrollee.

a. Team composition. The members of the interdisciplinary team must primarily serve PACE enrollees. At a minimum, the interdisciplinary team shall be composed of the following members:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) PACE center manager.

(9) Home care coordinator.

(10) Personal care attendant or attendant’s representative.

(11) Driver or driver’s representative.

b. Team responsibilities. Each enrollee shall be assigned to an interdisciplinary team functioning at the PACE center that the enrollee attends. The interdisciplinary team is responsible for the initial assessment, periodic reassessments, plan of care, and coordination of 24-hour care delivery for each assigned enrollee. Each interdisciplinary team member is responsible for the following:

(1) Regularly informing the team of the medical, functional, and psychosocial condition of each enrollee.

(2) Remaining alert to pertinent input from other team members, enrollees, and caregivers.

(3) Documenting changes in an enrollee's condition in the enrollee's medical record, consistent with documentation policies established by the medical director.

c. Exchange of information. The PACE organization must establish, implement, and maintain documented internal procedures governing the exchange of information between team members, contractors, and enrollees and their caregivers consistent with the federal requirements for confidentiality in 42 CFR Section 460.200(e) as amended to November 24, 1999.

88.86(2) Initial assessment. The interdisciplinary team must conduct an initial comprehensive assessment of each enrollee promptly following enrollment.

a. Each of the following members of the interdisciplinary team must evaluate the enrollee, at appropriate intervals, and develop a discipline-specific assessment of the enrollee's health and social status:

(1) Primary care physician.

(2) Registered nurse.

(3) Master's-level social worker.

(4) Physical therapist.

(5) Occupational therapist.

(6) Recreational therapist or activity coordinator.

(7) Dietitian.

(8) Home care coordinator.

b. At the recommendation of interdisciplinary team members, other professional disciplines (such as speech-language pathology, dentistry, or audiology) may be included in the comprehensive assessment process.

c. The assessment of each enrollee must include, but not be limited to, assessment of the following:

(1) Physical and cognitive function and ability.

(2) Medication use.

(3) Enrollee and caregiver preferences for care.

(4) Socialization and availability of family support.

(5) Current health status and treatment needs.

(6) Nutritional status.

(7) Home environment, including home access and egress.

(8) Enrollee behavior.

(9) Psychosocial status.

(10) Medical and dental status.

(11) Enrollee language.

88.86(3) Plan of care. The interdisciplinary team must promptly consolidate discipline-specific assessments into a single plan of care for each enrollee through discussion in team meetings and consensus of the entire team.

a. Development. The interdisciplinary team must develop, review, and reevaluate the plan of care in collaboration with the enrollee or caregiver, or both, to ensure that there is agreement with the plan of care and that the enrollee's concerns are addressed. In developing the plan of care, female enrollees must be informed that they are entitled to choose a qualified specialist for women's health services from the PACE organization's network to furnish routine or preventive women's health services.

b. Content. The plan of care must:

(1) Specify the care needed to meet the enrollee's medical, physical, emotional, and social needs, as identified in the initial comprehensive assessment.

(2) Identify measurable outcomes to be achieved.

c. Documentation. The interdisciplinary team shall document in the enrollee's medical record the plan of care and any changes made to the plan of care.

d. Implementation. The interdisciplinary team shall:

(1) Implement, coordinate, and monitor the plan of care, whether the services are furnished by PACE employees or contractors; and

(2) Continuously monitor the enrollee's health and psychosocial status, as well as the effectiveness of the plan of care, through the provision of services, informal observation, input from enrollees and caregivers, and communications among team members and other providers.

e. Evaluation. On at least a semiannual basis, the interdisciplinary team shall reevaluate the plan of care, including defined outcomes, and make changes as necessary.

88.86(4) Reassessment.

a. Semiannual reassessment. On at least a semiannual basis, or more often if an enrollee's condition dictates, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Primary care physician.
- (2) Registered nurse.
- (3) Master's-level social worker.
- (4) Recreational therapist or activity coordinator.
- (5) Other interdisciplinary team members actively involved in the development or implementation of the enrollee's plan of care, such as the home care coordinator, physical therapist, occupational therapist, or dietitian.

b. Annual reassessment. On at least an annual basis, the following interdisciplinary team members must conduct an in-person reassessment:

- (1) Physical therapist.
- (2) Occupational therapist.
- (3) Dietitian.
- (4) Home care coordinator.

c. Unscheduled reassessments. In addition to annual and semiannual reassessments, unscheduled reassessments may be required based on the following:

(1) A change in enrollee status. If the health or psychosocial status of an enrollee changes, the interdisciplinary team members listed in paragraph 88.86(2) "a" must conduct an in-person reassessment.

(2) A request by the enrollee or designated representative. If an enrollee (or the enrollee's designated representative) believes that the enrollee needs to initiate, eliminate, or continue a particular service, the appropriate interdisciplinary team members, as identified by the interdisciplinary team, must conduct an in-person reassessment.

d. Changes to plan of care. Interdisciplinary team members who conduct a reassessment must:

- (1) Reevaluate the enrollee's plan of care.
- (2) Discuss any changes in the plan of care with the interdisciplinary team.
- (3) Obtain approval of the revised plan of care from the interdisciplinary team and the enrollee or the enrollee's designated representative.
- (4) Document all assessment and reassessment information in the enrollee's medical record.
- (5) Furnish to the enrollee any services included in the revised plan of care as a result of a reassessment as expeditiously as the enrollee's health condition requires.

88.86(5) Procedures for resolving enrollee request to change the plan of care. The PACE organization must have explicit procedures for timely resolution of a request by an enrollee or an enrollee's designated representative to initiate, eliminate, or continue a particular service.

a. Except as provided in paragraph "b" of this subrule, the interdisciplinary team must notify the enrollee or the enrollee's designated representative of its decision to approve or deny the request from the enrollee or the designated representative as expeditiously as the enrollee's condition requires, but no later than 72 hours after the date the interdisciplinary team receives the request.

b. The interdisciplinary team may extend the 72-hour period for notifying the enrollee or the designated representative of its decision to approve or deny the request by no more than five additional days if:

- (1) The enrollee or designated representative requests the extension; or

(2) The interdisciplinary team documents its need for additional information and how the delay is in the interest of the enrollee.

c. The PACE organization must:

(1) Explain to the enrollee or the enrollee's designated representative orally and in writing any denial of a request to change the plan of care; and

(2) Provide the specific reasons for the denial in understandable language.

d. The PACE organization is responsible for:

(1) Informing the enrollee or the enrollee's designated representative of the enrollee's right to appeal the decision as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(2) Describing both the standard and expedited appeals processes of the PACE organization, including the right to obtain and conditions for obtaining expedited consideration of an appeal of a denial of services as specified in 42 CFR Section 460.122 as amended to December 8, 2006.

(3) Describing the right to and conditions for continuation of appealed services through the period of an appeal as specified in 42 CFR Section 460.122(e) as amended to December 8, 2006.

e. If the interdisciplinary team fails to provide the enrollee with timely notice of the resolution of the request or fails to furnish the services required by the revised plan of care, this failure constitutes an adverse decision. The enrollee's request must be automatically processed by the PACE organization as an appeal in accordance with 42 CFR Section 460.122 as amended to December 8, 2006.

f. The PACE organization must submit all documentation related to an appeal to the attention of the PACE program manager at the following address: Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, Iowa 50315.

441—88.87(249A) Program administrative requirements. A PACE organization shall comply with the federal administrative requirements stated in 42 CFR Sections 460.60 through 460.82 as amended to December 8, 2006, including requirements relating to organizational structure, governing body, qualifications for staff who have direct contact with enrollees, training, program integrity, contracted services, oversight of direct care services, physical environment, infection control, transportation services, dietary services, fiscal soundness, and marketing.

88.87(1) Enrollee rights. A PACE organization shall comply with the federal participant rights requirements stated in 42 CFR Sections 460.110 through 460.124 as amended to December 8, 2006. Upon exhaustion of the PACE organization's appeal process, a Medicaid enrollee has the right to appeal to the department any adverse coverage or payment decision regarding any service, including any denial, reduction, or termination of any service, pursuant to 441—Chapter 7.

88.87(2) Data collection, record maintenance, and reporting. A PACE organization shall comply with federal data collection, records maintenance, and reporting requirements stated in 42 CFR Sections 460.200 through 460.210 as amended to December 8, 2006.

88.87(3) Quality assessment and performance improvement. A PACE organization shall comply with the federal quality assessment and performance improvement requirements stated in 42 CFR Sections 460.130 through 460.140 as amended to November 24, 1999.

88.87(4) Federal and state monitoring.

a. The PACE program shall cooperate with federal and state monitoring pursuant to 42 CFR Sections 460.190 through 460.196 as amended to Nov. 24, 1999, including:

(1) Corrective action required pursuant to 42 CFR Section 460.194; and

(2) Disclosure of review results pursuant to 42 CFR Section 460.196(c) and (d).

b. The PACE program is subject to sanctions or termination pursuant to subrules 88.83(3) and 88.83(4).

c. During the trial period, CMS, in cooperation with the department, shall conduct comprehensive annual reviews of the operations of a PACE organization to ensure compliance with PACE federal regulations and 441—Chapter 88, Division V.

d. After the trial period, the department, in cooperation with CMS, shall conduct on-site reviews of a PACE organization at least every two years.

e. After a review, CMS and the department shall report the results of the review to the PACE organization, along with any recommendations for changes to the organization's program.

f. Within 30 days of issuance of the report, the PACE organization shall develop and implement a corrective action plan to address any deficiencies identified through the review.

g. CMS or the department shall monitor the effectiveness of the corrective actions implemented.

441—88.88(249A) Payment.

88.88(1) *Medicaid payment to PACE organization.* Under a PACE program agreement, the department shall make a prospective monthly payment to the PACE organization of a capitation amount for each Medicaid enrollee. The monthly capitation payment amount shall be negotiated between the PACE organization and the department and shall be specified in the PACE program agreement.

a. The amount of the capitation payment:

(1) Shall be less than the amount that would otherwise have been paid under the Medicaid program if the enrollees were not enrolled under the PACE program.

(2) Shall be a fixed amount regardless of changes in the enrollee's health status.

(3) May be renegotiated on an annual basis.

b. The PACE organization must accept the capitation payment amount as payment in full for Medicaid enrollees. The organization shall not collect or receive any other form of payment from the department or from, or on behalf of, the enrollee except for any amounts due from the enrollee pursuant to subrule 88.88(2).

88.88(2) *Liability of Medicaid enrollee.* A Medicaid enrollee shall contribute toward the cost of the enrollee's care according to the terms of this subrule. A PACE organization may not charge a premium to a Medicaid enrollee except for any amounts due pursuant to this subrule.

a. *Institutionalized enrollees.* Medicaid enrollees who reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the exceptions allowed by 441—subrule 75.16(1) and the deductions allowed by 441—subrule 75.16(2).

b. *Noninstitutionalized enrollees.* Medicaid enrollees who do not reside in a medical facility are liable to the PACE organization for the Medicaid capitation payment to the extent of their total monthly income, with the deductions required by 42 CFR Section 435.726(c) as amended to July 25, 1994, with maintenance needs amounts set at the following levels:

(1) The amount for the maintenance needs of the enrollee is set at 300 percent of the maximum SSI grant for an individual.

(2) The additional amount for the maintenance needs of a spouse at home is set at the Iowa Medicaid program's medically needy income standard for one person.

(3) The additional amount for the maintenance needs of a family at home is set at the Iowa Medicaid program's medically needy income standard for a family of the same size, to the extent that amount exceeds any amount allowed for the maintenance needs of a spouse at home.

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

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[◇] Two or more ARCs

¹ Effective date of 8/1/88 delayed 30 days by the Administrative Rules Review Committee at its July 1988 meeting.

² Effective date of 4/1/90 delayed 70 days by the Administrative Rules Review Committee at its March 12, 1990, meeting; delay lifted by this Committee, effective May 11, 1990.

CHAPTER 92 IOWACARE

PREAMBLE

This chapter defines and structures the IowaCare program administered by the department pursuant to Iowa Code Supplement chapter 249J. It is the department's intent that all state expenditures under the IowaCare program shall qualify for federal financial participation under Title XIX of the Social Security Act (Medical Assistance or Medicaid), as allowed by waivers of Title XIX requirements granted by the Secretary of the U.S. Department of Health and Human Services pursuant to Section 1115 of the Social Security Act (42 U.S.C. §1315). Therefore, this chapter shall remain in effect only as long as such waivers are effective. Further, this chapter shall be construed to comply with the requirements of Title XIX or with the terms of any applicable waiver of Title XIX requirements. To the extent that these rules may be found to be inconsistent with any applicable requirement of Title XIX or the terms of any applicable waiver, the requirements of Title XIX or the terms of the waiver shall prevail.

441—92.1(249A,249J) Definitions.

"Applicant" means an individual who applies for medical assistance under the IowaCare program described in this chapter.

"Clean claim" means a claim that can be adjudicated in the Medicaid claims payment system to result in either a paid or denied status.

"Department" means the Iowa department of human services.

"Dependent child" means the child or stepchild of an applicant or member who is living in the applicant's or member's home and is under the age of 18 or is 18 years of age and will graduate from high school or an equivalent level of vocational or technical school or training leading to a certificate or diploma before reaching the age of 19. Correspondence school is not an allowable program of study. "Dependent child" shall also include a child attending college or a school of higher learning beyond high school if the parents will claim the child as a dependent on their state or federal income tax return.

"Enrollment period" means the entire period that a member receives IowaCare without a break, which may include multiple certification periods.

"Federal poverty level" means the poverty income guidelines revised annually and published in the Federal Register by the U.S. Department of Health and Human Services.

"Group health insurance" means any plan of or contributed by an employer (including a self-insured plan) to provide health care (directly or otherwise) to the employer's employees, former employees, or the families of the employees or former employees.

"Initial application" means the first application for IowaCare or an application that is filed after a break in assistance of one month or more.

"IowaCare" means the medical assistance program explained in this chapter.

"Medical expansion services" means the services described in Iowa Code section 249J.6.

"Medical home" means a team approach to providing health care that originates in a primary care setting; fosters a partnership among the patient, the personal provider, other health care professionals, and where appropriate, the patient's family; utilizes the partnership to access all medical and nonmedical health-related services needed by the patient and the patient's family to achieve maximum health potential; maintains a centralized, comprehensive record of all health-related services to promote continuity of care; and has all of the characteristics specified in Iowa Code section 135.158.

"Member" means an individual who is receiving assistance under the IowaCare program described in this chapter.

"Newborn" means an infant born to a woman as defined in paragraph 92.2(1) "b."

"Nonparticipating provider" means a hospital that is located in Iowa and licensed pursuant to Iowa Code chapter 135B but that is not an IowaCare provider pursuant to subrule 92.8(1).

"Provider-directed care coordination services" means provider-directed services in a clinical setting aimed at managing all aspects of a patient's care to ensure quality of care and safety. All aspects of care

are coordinated by the clinical team under the direction of a physician. The team must include a dedicated care coordinator.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.2(249A,249J) Eligibility. IowaCare eligibility shall be determined according to the requirements of rules 441—75.2(249A) to 441—75.4(249A), 441—75.7(249A), 441—75.10(249A), and 441—75.12(249A) and the provisions of this rule.

92.2(1) Persons covered. Medical assistance under IowaCare shall be available to the following people as provided in this chapter:

a. Persons 19 through 64 years of age who:

(1) Are not eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40) or 75.1(42), including persons unable to meet spenddown under 441—subrule 75.1(35); and

(2) Have countable income at or below 200 percent of the federal poverty level.

b. Pregnant women whose:

(1) Gross countable income is below 300 percent of the federal poverty level; and

(2) Allowable medical expenses reduce their countable income to 200 percent of the federal poverty level or below.

c. Newborn children born to women defined in paragraph “*b.*”

92.2(2) Citizenship. To be eligible for IowaCare benefits, a person must meet the requirements in 441—subrule 75.11(2). A person who claims a qualified alien status shall provide documentation of this status.

92.2(3) Other disqualification. A person who has been disqualified from Medicaid for reasons other than excess income, excess resources, or lack of categorical eligibility is not eligible for IowaCare benefits.

92.2(4) Group health insurance. A person who has access to group health insurance is not eligible for IowaCare. The department shall use Form 470-4542, IowaCare Insurance Information Request, to obtain information to confirm the status of an IowaCare member’s group health insurance. An applicant or member shall not be considered to have access to group health insurance if any of the following conditions exist:

a. The applicant or member is not enrolled in the available group health plan and states that:

(1) The coverage is unaffordable; or

(2) Exclusions for preexisting conditions apply; or

(3) The needed services are not services covered by the plan.

b. The applicant or member is enrolled in a group health plan but states that:

(1) Exclusions for preexisting conditions apply; or

(2) The needed services are not covered by the plan; or

(3) The limits of benefits under the plan have been reached; or

(4) The plan includes only catastrophic health care coverage.

92.2(5) Payment of assessed premiums. IowaCare will be canceled if premiums are not paid in accordance with 441—92.7(249A,249J). However, an application for IowaCare shall not be affected by any unpaid premiums from any previous certification period.

92.2(6) Availability of funds. Eligibility for IowaCare shall not be approved when the department has determined that there are insufficient funds available to pay for additional enrollment, in accordance with 441—92.14(249A,249J).

[ARC 8505B, IAB 2/10/10, effective 4/1/10; ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.3(249A,249J) Application. Medicaid application policies in 441—76.1(249A) and 441—76.8(249A) apply to IowaCare except as follows:

92.3(1) An application for IowaCare may also be submitted on Comm. 239, IowaCare Application, or Form 470-4364, IowaCare Renewal Application. An applicant who submits an application on another form allowed under 441—76.1(249A) and has income over 150 percent of the federal poverty level shall also sign Form 470-4194, IowaCare Premium Agreement, and submit it within ten days of the department’s request.

92.3(2) A new application is required for each certification period.
[ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 9982B, IAB 2/8/12, effective 4/1/12]

441—92.4(249A,249J) Application processing. Department staff shall process IowaCare applications. The department shall base eligibility decisions primarily on information declared by the applicant. A face-to-face interview is not required.

92.4(1) Verification. Applicants seeking eligibility under 92.2(1)“b” shall provide verification of medical expenses as required under 92.5(5)“b.” IowaCare applicants shall not be required to provide verification of income, household members, disability, social security number, age, HAWK-I premium, group health insurance, or pregnancy, unless the verification is specifically requested in writing.

a. The department shall notify the person in writing of any further verification requested. The person shall have five working days to supply the requested information. The local office may extend the deadline for a reasonable period when the person is making every effort but is unable to secure the required information or verification from a third party.

b. Failure of the person to supply requested information or refusal by the person to authorize the department to secure the information from other sources shall serve as a basis for denial of an application or cancellation of IowaCare benefits.

c. If benefits are denied or canceled for failure to provide information and the information is provided within 14 calendar days of the effective date of the denial or cancellation, the department shall complete the eligibility determination as though the information were received timely. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information.

92.4(2) Screening for full Medicaid. The department shall screen each application for eligibility under coverage groups listed in 441—75.1(249A). If the applicant is eligible under another coverage group, the IowaCare application shall be considered an application for that coverage group.

92.4(3) Time limit for decision. The department shall make a determination of approval or denial as soon as possible, but no later than three working days after the filing date of the application, unless:

a. One or more conditions listed in 441—subrule 76.3(1), 76.3(3), 76.3(4), or 76.3(6) exist; or

b. The application is being processed for Medicaid eligibility under a coverage group listed in 441—75.1(249A).

[ARC 8500B, IAB 2/10/10, effective 3/1/10]

441—92.5(249A,249J) Determining income eligibility. The department shall determine the income of an applicant’s household as of the date of decision. To be eligible, the household’s income minus allowable deductions shall not exceed 200 percent of the federal poverty level for the household size.

92.5(1) Household size. The household size shall include the applicant and the applicant’s dependent or unborn children and spouse living in the same home, except when a dependent child or spouse has elected to receive supplemental security income under Title XVI of the Social Security Act. A person who is absent from the home shall not be included in the household size, unless the absence is temporary.

a. An applicant’s spouse shall not be considered absent from the home when:

(1) The spouse’s absence is due solely to a pattern of employment, including active duty in the uniformed services of the United States.

(2) The spouse 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.

b. The conditions described in 441—paragraph 75.53(4)“b” shall be applied to determine whether a person’s absence is temporary.

92.5(2) Self-declaration of income. Applicants shall self-declare the household’s future unearned and earned income based on their best estimate.

a. Applicants who receive income on a regular basis shall declare their household’s monthly income as described at 92.5(3) and 92.5(4).

b. Applicants who are self-employed, receive their income on an irregular basis, or are not currently employed shall declare their household's anticipated yearly income as described in 92.5(3) and 92.5(4).

92.5(3) Earned income. All earned income as defined in this subrule that is received by a person included in the household size shall be counted except for the earnings of a child who is a full-time student as defined in 441—subparagraphs 75.54(1) “*b*”(1), (2), and (3). Earned income shall include income in the form of a salary, wages, tips, or profit from self-employment.

a. For income from salary, wages, or tips, earned income shall mean the total gross amount of income irrespective of the expenses of employment.

b. For self-employment income, earned income shall mean the net profit from self-employment, defined as gross income less the costs of producing the income.

c. 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 the net profit counted as earned income 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 verifies expenses in excess of 40 percent of the total gross income received, the net profit counted as earned income shall be determined in the same manner as specified at paragraph 92.5(3) “*b.*”

92.5(4) Unearned income. Unearned income of all household members shall be counted unless exempted as income by:

a. 441—subrule 75.57(6), paragraph “*b,*” “*c,*” “*d,*” “*e,*” “*f,*” “*g,*” “*h,*” “*i,*” “*j,*” “*k,*” “*l,*” “*m,*” “*p,*” “*q,*” “*r,*” “*t,*” “*u,*” “*v,*” “*w,*” “*x,*” “*y,*” “*z,*” or “*aa*”; or

b. 441—subrule 75.57(7), paragraph “*a,*” “*b,*” “*c,*” “*d,*” “*e,*” “*f,*” “*g,*” “*h,*” “*i,*” “*j,*” “*k,*” “*l,*” “*m,*” or “*q.*”

92.5(5) Deductions. The department shall determine a household's countable income by deducting the following from the household's self-declared income:

a. Twenty percent of the household's self-declared earned income.

b. For women applying under 92.2(1) “*b,*” medical expenses incurred for a person included in the household size that are unpaid and not subject to payment by a third party. Verification of the unpaid expenses must be provided in order to receive the deduction. The medical expenses that can be deducted are:

- (1) Health insurance premiums, deductibles, or coinsurance charges; and
- (2) Medical and dental expenses.

92.5(6) Disregard of changes. A person found to be income-eligible upon application or recertification of eligibility shall remain income-eligible for 12 months regardless of any change in income or household size.

92.5(7) Unearned nonrecurring lump-sum income. All unearned nonrecurring lump-sum income shall be disregarded.

92.5(8) Earned lump-sum income. Anticipated earned lump-sum income shall be prorated over the period for which the income is received.

441—92.6(249A,249J) Effective date. The department shall issue Form 470-4164, IowaCare Medical Card, to persons enrolled in the IowaCare program.

92.6(1) Certification period. IowaCare eligibility 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. The certification period shall continue for 12 consecutive months. EXCEPTIONS:

a. For women and newborns eligible under 92.2(1) “*b*” or “*c,*” the certification period shall continue until 60 days after the birth of the child.

b. Certification periods may be adjusted if two or more IowaCare members who were in two households are combined into one household for premium purposes.

92.6(2) Retroactive eligibility. IowaCare benefits shall also be available for the month preceding the month in which the application is filed if during that preceding month:

a. The applicant received Medicaid expansion services from a provider within the Medicaid expansion network; and

b. The applicant would have been eligible for IowaCare if application had been made.

92.6(3) Care provided before eligibility. No payment shall be made for medical care received before the effective date of eligibility.

92.6(4) Reinstatement. Eligibility for IowaCare may be reinstated without a new application when all information necessary to establish eligibility, including verification of any changes, is provided within 14 calendar days of the effective date of the cancellation. If the fourteenth calendar day falls on a weekend or state holiday, the client shall have until the next business day to provide the information. When eligibility can be reestablished, assistance shall be reinstated with an effective date of the first day of the month following the month of cancellation.

[ARC 8500B, IAB 2/10/10, effective 3/1/10; ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.7(249A,249J) Financial participation. In addition to the copayments required by 441—subrule 79.1(13), IowaCare members, with the exception of newborns eligible pursuant to 92.2(1) “c” and members in households that include a considered person who pays a Medicaid premium, shall be assessed a sliding-scale monthly premium. A member shall be responsible for paying the premium for the first month after the month of decision and for the following three months, regardless of continued enrollment during the four-month period or during previous months, and for each month of continued enrollment after the required four months. If there is a break in enrollment of one month or more, a new four-month period of mandatory premiums shall be assessed, beginning with the month following the month of decision.

92.7(1) Premium amount. The monthly premium amount shall be established for the certification period determined pursuant to subrule 92.6(1) beginning with the first month of eligibility, based on projected monthly income for 12 months. On an initial application, no premium shall be assessed for months of eligibility before and including the month of decision, including the retroactive month.

a. The monthly premium is based on the household’s countable monthly income as a percentage of the federal poverty level for a household of that size. If there is more than one IowaCare member in a household, a single premium is established for coverage of all of the members in the household. Subject to the annual update pursuant to paragraph 92.7(1) “b,” for certification periods beginning on or after April 1, 2012, premiums are as follows:

When there is one IowaCare member in the household and the household’s income is at or below:	The member’s premium amount is:
150% of federal poverty level	\$0
160% of federal poverty level	\$51
170% of federal poverty level	\$55
180% of federal poverty level	\$58
190% of federal poverty level	\$61
200% of federal poverty level	\$65

When there are two or more IowaCare members in the household and the household's income is at or below:	The household's premium amount is:
150% of federal poverty level	\$0
160% of federal poverty level	\$69
170% of federal poverty level	\$73
180% of federal poverty level	\$78
190% of federal poverty level	\$82
200% of federal poverty level	\$86

b. The listed premium amount is calculated based on the lowest income level in each 10 percent increment of the federal poverty level for a household of one if there is one IowaCare member in the household or of the federal poverty level for a household of two if there are two or more IowaCare members in the household.

(1) Households with income at or below 150 percent of the poverty level are not subject to a premium.

(2) Premiums for households with income over 150 percent of the poverty level are 3.5 percent of the lowest applicable income level. The department will update these amounts effective the second month after the month federal poverty level guidelines are released.

c. The cost of HAWK-I premiums paid for household members shall be deducted from the premium assessed according to this subrule.

d. The monthly premium established for a certification period shall not be increased due to an increase in household income or a change in household size.

e. The premium may be reduced prospectively during the certification period if a member declares a reduction in projected average monthly household income or an increase in household size or is granted a hardship exemption.

92.7(2) Billing and payment. Form 470-4165, IowaCare Billing Statement, shall be used for billing and collection.

a. Method of payment. Members shall submit premium payments to the following address: Iowa Medicaid Enterprise, IowaCare Premiums, P.O. Box 10391, Des Moines, Iowa 50306-9013.

b. Due date. When the department notifies a member of the amount of the premium, the member or household shall pay any premiums due as follows:

(1) The premium for each month is due the last calendar day of the month the premium is to cover. EXCEPTION: The premiums for the months covered in the initial billing are due the last calendar day of the following month.

(2) If the last calendar day falls on a weekend or a state or federal holiday, payment is due the first working day following the holiday or weekend.

c. Application of payment. The department shall apply premium payments received to the oldest unpaid month in the current certification period. When premiums for all months in the certification period have been paid, the department shall hold any excess and apply it to any months for which eligibility is subsequently established.

92.7(3) Hardship exemption. A member or household that submits a written statement indicating that payment of the monthly premium will be a financial hardship shall be exempted from premium payment for that month, except as provided in paragraph "c."

a. If the statement is not received by five working days after the premium due date, the member or household shall be obligated to pay the premium.

b. If the statement is timely submitted with a partial payment, exemption shall be granted for the balance owed for that month.

c. A member or household shall not be exempted from premium payment for a month in which the member misrepresented the household's circumstances.

92.7(4) Failure to pay premium. If the member or household fails to pay the assessed premium or to declare a hardship by the date the premium is due, the department shall cancel IowaCare benefits effective 60 days after the due date and shall refer the unpaid premiums for collection. A member whose IowaCare benefits are canceled due to nonpayment of premiums must reapply to establish IowaCare eligibility.

92.7(5) Refund of premium. When a member's IowaCare coverage is canceled due to a circumstance listed in paragraph "a," premiums paid for any period after the cancellation date shall be refunded, except to the extent that premiums are still due for any household members whose IowaCare coverage is not canceled.

a. Premiums may be refunded when a member's IowaCare coverage is canceled because the member:

- (1) Is determined eligible for medical assistance under 441—subrules 75.1(1) through 75.1(40);
- (2) Has access to group health insurance coverage as defined in subrule 92.2(4);
- (3) Reaches age 65;
- (4) Dies; or
- (5) No longer meets program requirements after the four mandatory premium months.

b. The amount of the refund shall be offset by any outstanding premiums owed.

c. Any excess premium received for a person who is not receiving IowaCare benefits shall be refunded:

- (1) Two calendar months after eligibility ended unless an application or reapplication is pending,

or

- (2) Upon the person's request.

d. Any excess premium received for an IowaCare member shall be refunded:

- (1) After two calendar months of a zero premium, or
- (2) Upon the member's request.

[ARC 7667B, IAB 4/8/09, effective 4/1/09; ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 9532B, IAB 6/1/11, effective 7/6/11; ARC 9982B, IAB 2/8/12, effective 4/1/12; ARC 0151C, IAB 6/13/12, effective 7/18/12]

441—92.8(249A,249J) Benefits. Under IowaCare, payment will be made only for services and providers as specified in this rule. No payment will be made for any service provided elsewhere or by another provider.

92.8(1) Provider network. Except as provided in subrules 92.8(3) through 92.8(6), IowaCare members shall have medical assistance only for services provided to the member by:

- a. The University of Iowa Hospitals and Clinics; or
- b. Broadlawns Medical Center in Des Moines; or

c. A federally qualified health center that the department has designated as part of the IowaCare network using a phased-in approach based on the degree to which the area is underserved, medical home readiness, and the availability of funds; or

d. Any physician, advanced registered nurse practitioner, or physician assistant who is part of a medical institution listed in this subrule. Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

92.8(2) Covered services. Services shall be limited to the services covered by the Iowa Medicaid program pursuant to 441—Chapter 78 or 441—79.9(249A) and to medical home services required by subrule 92.8(7). All conditions of service provision shall apply in the same manner as under the regular Iowa Medicaid program and pursuant to 441—Chapter 78, 441—79.3(249A), 441—79.5(249A), 441—79.6(249A), 441—79.8(249A) through 441—79.14(249A), and applicable provider manuals. These conditions include, but are not limited to, prior authorization requirements and exclusions for cosmetic procedures or those otherwise determined not to be required to meet the medical need of the patient.

92.8(3) Obstetric and newborn coverage. IowaCare members who qualify under 92.2(1) "b" or "c" are also eligible for the services specified in paragraph "a" or "b" from the providers specified in paragraph "c" or "d."

- a.* Covered services for pregnant women shall be limited to:
- (1) Inpatient hospital services when the diagnosis-related group (DRG) submitted for payment is between 370 and 384 and the primary or secondary diagnosis code is V22 through V24.9.
 - (2) Obstetrical services provided in an outpatient hospital setting when the primary or secondary diagnosis code is V22 through V24.9.
 - (3) Services from another provider participating in Medicaid if the claim form reflects that the primary or secondary diagnosis code is V22 through V24.9.
- b.* Newborns will be eligible while hospitalized and for a period not to exceed 60 days from the date of birth.
- (1) Inpatient hospital services shall be payable when the diagnosis-related group (DRG) submitted for payment is between 385 and 391.7.
 - (2) Services provided by a health care provider other than a hospital shall be covered as provided in subrule 92.8(2).
- c.* For persons who reside in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County, the services listed in this subrule are covered only when provided by the University of Iowa Hospitals and Clinics.
- d.* Persons who do not live in Cedar, Clinton, Iowa, Johnson, Keokuk, Louisa, Muscatine, Scott, or Washington County may obtain the services listed in this subrule from any provider that participates in Iowa Medicaid.

92.8(4) Routine preventive medical examinations. A routine preventive medical examination is one that is performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury.

a. IowaCare members who qualify under paragraph 92.2(1) “*b*” or “*c*” and who have not been enrolled with a medical home are eligible to receive routine preventive medical examinations from:

- (1) Any provider specified under subrule 92.8(1), or
- (2) Any physician, advanced registered nurse practitioner, or physician assistant who participates in Iowa Medicaid, including but not limited to providers available through a free clinic, a rural health clinic, or a federally qualified health center that has not been designated as an IowaCare provider pursuant to paragraph 92.8(1) “*c*.” Physician assistants are able to render covered services as auxiliary personnel of a physician pursuant to 441—subrule 78.1(13).

b. A provider that bills IowaCare for a routine preventive medical examination shall use diagnosis code V70 and evaluation and management CPT code 99202, 99203, 99204, 99212, 99213, or 99214, as appropriate to the level of service provided. Basic laboratory work may also be billed in association with the medical examination, as appropriate and necessary.

92.8(5) Drugs for smoking cessation. IowaCare members may obtain outpatient prescription drugs for smoking cessation that are related to another appropriately billed IowaCare service from any pharmacy participating in the Iowa Medicaid program.

92.8(6) Medical home. As a condition of participation in the IowaCare program, network providers designated pursuant to subrule 92.8(1) must also qualify as medical homes, pursuant to Iowa Code chapter 135, division XXII.

a. The provider shall meet medical home standards. If the Iowa department of public health adopts rules that provide statewide medical home standards or provide for a statewide medical home certification process, those rules shall apply to IowaCare medical home providers and shall take precedence over the requirements in this paragraph. At a minimum, medical homes shall:

- (1) Have National Committee for Quality Assurance (NCQA) Level 1 certification or equivalent certification. Effective July 1, 2011, medical homes that achieve a higher level of accreditation from NCQA or equivalent shall be designated as such for purposes of payment.
- (2) Provide provider-directed care coordination services.
- (3) Provide members with access to health care and information.
- (4) Provide wellness and disease prevention services.
- (5) Create and maintain chronic disease information in a searchable disease registry.
- (6) Demonstrate evidence of implementation of an electronic health record system.

(7) Participate in and report on quality improvement processes.

b. The provider shall execute a contract with the department to be an IowaCare medical home and receive enhanced medical home reimbursements pursuant to subrule 92.9(4). The contract shall include performance measurements and specify expectations and standards for a medical home.

c. If an IowaCare member resides in a designated county near a designated medical home provider, the department shall assign the member to that provider. If an IowaCare member who is assigned to a medical home chooses to go to another provider without a referral from the medical home:

(1) The service is not covered by the IowaCare program, and

(2) The provider may bill the member according to the provider's established criteria for billing other patients.

92.8(7) Services from nonparticipating providers.

a. A nonparticipating provider hospital may be reimbursed for covered IowaCare services subject to the following conditions and limitations:

(1) The patient is enrolled in IowaCare pursuant to the Iowa Medicaid enterprise eligibility verification system at the time the services are delivered.

(2) The services are emergency services, as designated by the department, and it is not medically possible to postpone provision of those services.

(3) It is not medically possible to transfer the member to an IowaCare provider, or the IowaCare provider does not have sufficient capacity to accept the member.

(4) The provision of emergency services is followed by an inpatient admission at the nonparticipating provider.

(5) Before submitting a medical claim for reimbursement, the treating nonparticipating provider has requested and received authorization for payment from the Iowa Medicaid enterprise medical services unit. The request shall include the claim listing the emergency and inpatient services.

b. If the conditions listed in paragraph "a" are met as specified, a nonparticipating provider may be reimbursed for covered services provided to the member from the point of emergency room admission to the point of discharge or transfer from the inpatient unit, up to the amount appropriated. This reimbursement does not include emergency or nonemergency transportation services.

c. Care coordination pool. A care coordination pool is established to provide payment for medically necessary services provided to IowaCare members for continuation of care provided by a participating IowaCare hospital. Reimbursement is available from designated care coordination pool funding subject to the following conditions:

(1) Payment may be made for continuing care that is related to an IowaCare member's hospital services as determined in a referral from the participating IowaCare hospital.

(2) Payment for continuing care is available to providers that are enrolled in the Iowa medical assistance program, regardless of whether the provider is a participating provider for IowaCare and regardless of the member's county of residence or medical home assignment.

(3) A provider of continuing care that does not participate in the IowaCare program must include information regarding the referral on the claim form.

(4) Payment shall be made only for services that are not otherwise covered under the IowaCare program. Payment shall not be made for services that would normally be provided by the IowaCare provider to other non-IowaCare patients.

(5) The type, scope, and duration of payable services shall be limited as determined by the department. Payable services are limited to:

1. Durable medical equipment.

2. Home health services.

3. Rehabilitation and therapy services, including intravenous antibiotics and parenteral therapy delivered at home.

(6) Types of items or services that are not covered include, but are not limited to:

1. Adult diapers.

2. Air compressors.

3. Bedside commodes.

4. Blood pressure kits or machines.
5. Cardiac event monitors.
6. Continuous passive motion machines.
7. Continuous positive air pressure (CPAP) machines.
8. Dental care (nonsurgical).
9. Eyeglasses, contact lenses, and eye prostheses.
10. Gel shoe inserts.
11. Hearing aids.
12. Heated oxygen.
13. Laboratory tests and radiology procedures.
14. Oral supplemental formula.
15. Outpatient pharmaceuticals not specifically identified in 92.8(7)“c”(5) above.
16. Ted hose, Sigvaris stockings, or Jobst stockings.
17. Tennis shoes.
18. Transcutaneous electrical nerve stimulation (TENS) units.
19. Transportation.
20. Work boots.

(7) All other medical assistance program policies affecting the payable services shall apply, including those regarding prior authorization and level of care determination.

(8) Payment is limited to the amount of available funds designated for the care coordination pool.

d. Laboratory test and radiology pool. A funding pool is established to provide payment for medically necessary laboratory tests and radiology services provided to enrolled IowaCare members when authorized by a federally qualified health center that has been designated by the department as part of the IowaCare regional provider network. Payment from the pool shall be subject to the following conditions and limitations:

(1) Payment may be made only for laboratory tests or radiology services which the participating federally qualified health center does not otherwise have the means to provide on site.

(2) Each participating federally qualified health center shall designate no more than four laboratory testing facilities and no more than four radiology facilities to which the center will refer IowaCare patients for these services. The designated providers must participate in the Iowa medical assistance program. Payment shall be made only to the designated providers.

(3) The designated provider must obtain a referral from the participating federally qualified health center for the services and must include information regarding the referral on the claim form.

(4) All other medical assistance policies for coverage of laboratory and radiology services shall apply, including requirements for prior authorization.

(5) Payment is limited to the amount of available funds designated for the laboratory test and radiology pool. If the amount appropriated for the pool is exhausted, laboratory tests and radiology services ordered by a participating federally qualified health center shall be provided or coordinated by the center.

92.8(8) Referral protocols. When an IowaCare primary care provider refers the member to an IowaCare specialty provider, the following conditions shall apply:

a. By January 1, 2012, IowaCare providers shall ensure that referral and patient access processes for IowaCare members are no more restrictive than the processes required for any other payor.

b. After an IowaCare provider makes a referral, the IowaCare provider receiving the referral shall report the following information to the referring provider in a manner chosen by the provider receiving the referral:

(1) The date an appointment has been scheduled. The appointment date shall be reported to the referring provider within 15 calendar days of receiving the referral. If the referral is denied, the receiving provider shall offer a consultation by telephone, fax, E-mail, or Internet regarding the reason for the denial.

(2) If authorized by the IowaCare member, the outcome of the appointment, including whether the appointment was kept, the treatment plan, and any follow-up instructions. This report shall be made no later than 15 calendar days following the appointment date.

c. IowaCare providers shall work together to address any communication or coordination issues that arise. By October 1, 2011, IowaCare providers shall jointly develop and implement:

(1) A process to resolve disputes regarding care needs, payment and referrals that includes regular meetings between providers.

(2) A process to identify and address quality improvements with a goal to improve coordination of care between primary, specialty and hospital care. This process shall be monitored by the department but be managed and staffed by the providers.

92.8(9) Other services provided by Broadlawns Medical Center. Broadlawns Medical Center shall be reimbursed for outpatient prescription drugs, podiatry services, optometric services, and durable medical equipment provided to members of the expansion population. Payment is limited to the amount of funds appropriated for this purpose.

[ARC 9135B, IAB 10/6/10, effective 10/1/10; ARC 9728B, IAB 9/7/11, effective 9/1/11; ARC 9890B, IAB 11/30/11, effective 1/4/12; ARC 9996B, IAB 2/8/12, effective 1/19/12; ARC 0200C, IAB 7/11/12, effective 7/1/12]

441—92.9(249A,249J) Claims and reimbursement methodologies.

92.9(1) Claims. Claims for Medicaid expansion services provided to IowaCare members shall be submitted to the Iowa Medicaid Enterprise, P.O. Box 150001, Des Moines, Iowa 50315, as required by 441—Chapter 80. To facilitate tracking of expenditures, clean claims for IowaCare services shall be submitted to the Iowa Medicaid enterprise within 20 days from ending date of service.

92.9(2) Payment for hospital services provided by IowaCare network. Effective July 1, 2010:

a. Inpatient hospital services provided by University of Iowa Hospitals and Clinics will be paid based on 100 percent of reasonable and allowable costs.

(1) An interim rate based on the Medicaid reimbursement rates and methodologies as of November 30, 2009, shall be used to price submitted claims.

(2) At the end of the cost reporting period, a reconciliation will be performed based on the hospital's CMS-2552 cost report as filed for the payment period and IowaCare claims data as extracted by the department from the Medicaid management information system. The aggregate payments under the interim methodology will be determined and compared to the IowaCare program costs as determined from the hospital's cost report. For purposes of this rule, aggregate payments include amounts received for the IowaCare program, outlier payments, and patient and third-party payments up to the allowed amount.

(3) If the aggregate payments exceed the hospital's IowaCare costs, the amount by which payments exceed actual costs will be requested and collected from the hospitals.

(4) If the aggregate payments are less than actual IowaCare costs, an additional payment equal to the difference will be made to the hospital.

b. Inpatient hospital services provided by Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

c. Outpatient hospital services provided by University of Iowa Hospitals and Clinics or Broadlawns Medical Center shall be paid at the Medicaid reimbursement rates and methodologies in effect on November 30, 2009.

92.9(3) Payment for nonhospital services provided by IowaCare network. Effective July 1, 2010, IowaCare network providers shall be paid for nonhospital services at the Medicaid fee schedule amounts in effect on November 30, 2009, with the following exceptions:

a. For preventive examination codes, the fee schedule amounts shall be based on the Medicaid physician fee schedule in effect on the date of service.

b. Physician services provided to IowaCare members in a federally qualified health center shall be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

c. Physician services provided by University of Iowa Hospitals and Clinics physicians to IowaCare members will be reimbursed based on the Medicaid physician fee schedule in effect on the date of service, limited to the amount appropriated for the fiscal year.

92.9(4) Medical home payments.

a. In addition to any other IowaCare reimbursement, IowaCare providers that meet the medical home standards pursuant to subrule 92.8(6) and have contracted with the department shall receive a monthly medical home payment for each member assigned to the medical home by the department. The medical home payment shall begin the first day of the month following the member's assignment to the medical home.

(1) The medical home payment will be on a per-member, per-month basis in an amount determined by the department, but no more than \$4 per member, per month.

(2) Effective July 1, 2011, the department shall implement a tiered per-member, per-month payment method that is based on the medical home's certification level as designated by a nationally recognized medical home accreditation organization.

b. IowaCare medical homes shall be eligible for a performance payment for achieving medical home performance benchmarks designated by the department as specified in the provider's contract with the department. The performance payment shall be paid by October 31 following the end of the state fiscal year and is in addition to any other IowaCare reimbursement.

92.9(5) Payment for services provided by nonparticipating hospitals. Nonparticipating hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on December 1, 2009, up to the amount appropriated to the nonparticipating provider reimbursement fund created in 2009 Iowa Code Supplement section 249J.24A. No payment shall be made after appropriated funds are exhausted.

92.9(6) Payment for services provided by other nonparticipating providers. Nonparticipating providers other than hospitals shall be paid at the Medicaid reimbursement rates and methodologies in effect on the date of service.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.10(249A,249J) Reporting changes.

92.10(1) Reporting requirements. A member shall report any of the following changes no later than ten calendar days after the change takes place:

- a. The member enters a nonmedical institution, including but not limited to a penal institution.
- b. The member abandons Iowa residency.
- c. The member obtains other health insurance coverage.

92.10(2) Untimely report. When a change is not timely reported, any incorrect program expenditures shall be subject to recovery in accordance with 441—92.13(249A,249J).

92.10(3) Effective date of change. After assistance has been approved, changes reported during the month that affect the member's eligibility or premium amount shall be effective the first day of the next calendar month unless:

- a. Timely notice of adverse action is required as specified in 441—subrule 7.7(1); or
- b. The certification has expired.

441—92.11(249A,249J) Reapplication. A new application is required when a member's 12-month certification period has expired or a member is seeking to regain eligibility after cancellation.

92.11(1) Reapplication at least three days before end of certification period. When a member submits an application before the last three working days of the member's current certification period, the department shall approve or deny the application by the last working day of the current certification period unless a condition described at 92.4(3) "a" or "b" applies.

92.11(2) Reapplication within three days of end of certification period or later. When a member submits an application during the last three working days of the member's current certification period or after the certification period ends, the department shall approve or deny the application as described at 92.4(3).

441—92.12(249A,249J) Terminating eligibility. IowaCare eligibility shall end when any of the following occur:

1. The certification period ends.
2. The member begins receiving medical assistance in a coverage group under 441—subrules 75.1(1) through 75.1(40).
3. The member does not pay premiums as required by 441—92.7(249A,249J).
4. The member no longer meets the nonfinancial eligibility requirements under 441—92.2(249A,249J).
5. The member is found to have been ineligible at the time the eligibility determination was made due to member misrepresentation or member or agency error.
6. The member dies.

441—92.13(249A,249J) Recovery. The department shall recover from a member all Medicaid funds incorrectly expended on behalf of the member and any unpaid premiums in accordance with 441—76.12(249A). For this purpose, unpaid premiums shall be treated as medical assistance incorrectly paid due to client error.

92.13(1) The department shall recover Medicaid funds expended on behalf of a member and any unpaid premiums from the member's estate in accordance with 441—76.12(249A).

92.13(2) Any funds recovered from third parties, including Medicare, by a provider other than a state mental health institute shall be submitted to the Iowa Medicaid enterprise, and an adjustment shall be made to a previously submitted claim.

[ARC 9135B, IAB 10/6/10, effective 10/1/10]

441—92.14(249A,249J) Discontinuance of the program. IowaCare is operated statewide and is funded on a fiscal-year basis (from July through June). When funds are expected to be expended before the end of the fiscal year, enrollment of new members into the program will be discontinued or limited to a reduced scope of services until funding is received for the next fiscal year.

92.14(1) Suspension of enrollment. To ensure equitable treatment, applications shall be approved on a first-come, first-served basis and enrollment will be suspended when the likely costs of caring for those already enrolled will exhaust the available funding during the year. "First-come, first-served" status is determined by the date the application is approved for eligibility and entered into the computer system.

92.14(2) Enrollment for limited services. Eligibility or payment for services received cannot be approved beyond the amount of funds available. Because funds are limited, applications may be approved for a reduced scope of services.

441—92.15(249A,249J) Right to appeal. Decisions and actions by the department regarding eligibility or services provided under this chapter may be appealed pursuant to 441—Chapter 7. However, households will not be entitled to an appeal hearing if the sole basis for denying or limiting services is due to discontinuance or limitation of the program pursuant to 441—92.14(249A,249J).

These rules are intended to implement Iowa Code chapter 249J.

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ENVIRONMENTAL PROTECTION COMMISSION[567]

Former Water, Air and Waste Management[900], renamed by 1986 Iowa Acts, chapter 1245, Environmental Protection Commission under the "umbrella" of the Department of Natural Resources.

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COMMERCIAL SEPTIC TANK CLEANERS

567—68.1(455B) Purpose and applicability. The purpose of this chapter is to implement Iowa Code subsection 455B.172(5) and 2011 Iowa Code Supplement section 455B.172A by providing standards for the commercial cleaning of and the disposal of waste from private sewage disposal systems and on-farm food processing operations and by providing licensing requirements and procedures. These rules govern the commercial cleaning of and the disposal of wastes from private sewage disposal systems and on-farm food processing operations.

[ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—68.2(455B) Definitions. For purposes of this chapter, the following terms shall have the meanings indicated:

“*Cleaning*” means removal of waste from private sewage disposal systems and other actions incidental to that removal.

“*Commercial septic tank cleaner*” means a person or firm engaged in the business of cleaning and disposing of waste from private sewage disposal systems, including a person or firm that owns and rents or leases portable toilets.

“*Department*” means the Iowa department of natural resources.

“*Food commodity*” means any commodity that is derived from an agricultural animal or crop, both as defined in Iowa Code section 717A.1, which is intended for human consumption in its raw or processed state.

1. A food commodity in its raw state for processing includes, but is not limited to, milk, eggs, vegetables, fruits, nuts, syrup, and honey.

2. A food commodity in its processed state includes, but is not limited to, dairy products, pastries, pies, and meat or poultry products.

“*Holding tank for waste*” means any receptacle for the retention or storage of waste pending removal for further treatment or disposal.

“*On-farm processing operation*” means any place located on a farm where the form or condition of a food commodity originating from that farm or another farm is changed or packaged for human consumption, including but not limited to a dairy, creamery, winery, distillery, cannery, bakery, or meat or poultry processor. “On-farm processing operation” does not include food commodities processed by a person exclusively for use by the person and members of the person’s household and the person’s nonpaying guests and employees.

“*Private sewage disposal system*” means a system which provides for the treatment or disposal of domestic sewage from four or fewer dwelling units or the equivalent of fewer than 16 individuals on a continuing basis, including domestic waste, whether residential or nonresidential, but not including industrial waste of any flow rate except as provided for in 567—68.11(455B). “Private sewage disposal system” includes, but is not limited to, septic tanks as defined in 567—subrule 69.1(2); holding tanks for waste; and impervious vault toilets, portable toilets, and chemical toilets as described in 567—69.15(455B).

“*Septage*” means the liquid and solid material pumped from a septic tank, cesspool, or similar domestic sewage treatment system, or from a holding tank, when the system is cleaned or maintained.

“*Tank*” means any container which is placed on a vehicle to transport waste removed from a private waste facility.

“*Toilet unit*” means a portable or fixed tank or vessel holding untreated human waste without secondary wastewater treatment which is emptied for disposal. “Toilet unit” does not include a portable or fixed tank or vessel holding untreated human waste that is part of a recreational vehicle or marine vessel.

“*Vehicle*” means a device used to transport a tank, including a trailer.

“*Waste*” means human or animal excreta, water, scum, sludge, septage, and grease solids from private sewage disposal.

[ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—68.3(455B) Licensing requirements. Commercial septic tank cleaners must annually apply for and obtain a license from the department before engaging in the commercial cleaning of and disposal of septage from any private sewage disposal system in the state of Iowa. The license period will run from July 1 to June 30 of the following year. The owner of a septic tank may clean the owner's own tank without being licensed if all other requirements of this chapter are met.

567—68.4(455B) Licensing procedures.

68.4(1) Application for license. A commercial septic tank cleaner must apply for a license by completing a form provided by the department and submitting it with an annual waste management plan and the license fee to the Department of Natural Resources, License Bureau, Henry A. Wallace Building, 502 E. 9th Street, Des Moines, Iowa 50319. In the case of a commercial septic tank cleaner which is a corporation, partnership, association or any other business entity, the entity itself must apply as provided in this rule. The entity shall designate one person, such as a partner, officer, manager, supervisor, or other full-time employee, to act as its representative for the purpose of applying for a license. Individuals employed by a commercial septic tank cleaner business are not required to be licensed, but each cleaning unit (vehicle or tank) must have the license number (except for the year) displayed and a copy of the current license with the cleaning unit.

68.4(2) Waste management plan. The applicant must submit as a part of the application a septage disposal management plan. The plan must also be submitted to the county board of health in each county where septage is to be land-applied. The plan shall include:

- a. The volume of septage expected to be collected from private sewage disposal facilities.
- b. The volume of septage to be taken to permitted publicly owned treatment works.
- c. A letter of acceptance from any publicly operated treatment works where waste is proposed to be disposed.
- d. The location and area of all sites where septage is to be land-applied.
- e. The anticipated volume of septage applied to each site.
- f. The type of crop to be planted on each site and when the crop is to be planted.
- g. The type of application to be used at each site.
- h. A list of vehicles to be registered.
- i. Rescinded IAB 7/11/12, effective 8/15/12.

Allowance may be made in the plan for septage application on the property of the owner of the tank being pumped as long as disposal standards of this chapter are met. A license will be issued only after approval of the waste management plan. If the plan is not approved, it must be modified and resubmitted.

68.4(3) License fee. The application fee is \$150 per year for the first registered vehicle and \$50 for each additional vehicle. If the applicant intends to land-apply any septage during the year, there will be an additional application fee of \$7 per 1,000 gallons of septage to be land-applied per year. Land application fees shall be based on the previous year's records. First-time applicants shall pay a \$300 annual land application fee if they propose to land-apply. New license applicants will be charged monthly prorated fees until the next June 30.

68.4(4) License renewal. In order to remain valid, a commercial septic tank cleaner license must be renewed by June 30 of each year. Renewal application must be made on a form provided by the department and must be received by the department or postmarked at least 30 days prior to the expiration date.

68.4(5) Change in ownership. Within 30 days of the change in ownership of any commercial septic tank cleaner, the new owner shall furnish the department with the following information:

- a. Name of business and license number;
- b. Name, address, and telephone number of new owner; and
- c. Date the change in ownership took place and any change in the waste management plan. The license will transfer with the ownership with no additional fee due until the next renewal date.

68.4(6) Change in address. Within 30 days of any change in the address or location of the business, information regarding such change must be reported to the department.

68.4(7) *Alteration of waste management plan.* An amended waste management plan must be submitted before any new property for land application not listed on the existing plan is used or waste is taken to a publicly operated treatment works not listed on the plan.

[ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—68.5(455B) Suspension, revocation and denial of license.

68.5(1) *Basis for suspension, revocation, and denial.* The department may suspend, revoke, or deny a commercial septic tank cleaner license for any of the following reasons:

- a. A material misstatement of facts in a license application.
- b. Failure to provide the adequate license fee.
- c. Failure to provide and adhere to an approved waste management plan.
- d. Failure to satisfy the obligations of a commercial septic tank cleaner and the standards as provided in rules 567—68.6(455B), 567—68.9(455B), and 567—68.10(455B).
- e. Failure to pay any fines assessed under 68.5(2).

68.5(2) *Civil penalties.* The department may assess civil penalties not to exceed \$250 for violations of this rule. Each day that the violation continues constitutes a separate offense.

68.5(3) *Appeal.* A commercial septic tank cleaner may appeal the suspension, revocation, or denial of a license under the provisions of 567—Chapter 7.

68.5(4) *Reinstatement.* In the case of a denial, revocation, or suspension pursuant to paragraph 68.5(1) “b” or “e,” the department may immediately reinstate or issue a license after receipt of the requisite fee or fine and confirmation that the commercial septic tank cleaner is fulfilling the requirements of rules 567—68.6(455B) and 567—68.9(455B). In case of a denial, revocation or suspension pursuant to paragraph 68.5(1) “a,” “c,” or “d,” the department may reinstate or issue a license no sooner than 60 days after the denial, revocation, or suspension if the department is satisfied that the commercial septic tank cleaner has corrected the deficiency and will comply with departmental rules in the future.

567—68.6(455B) Licensee’s obligations.

68.6(1) *Supervision.* The licensee shall provide supervision for the removal and disposal of septage from private sewage disposal systems.

68.6(2) *Standards.* The licensee shall meet the standards established in this chapter for the cleaning of and disposal of septage from private sewage disposal systems.

68.6(3) *Records.* The licensee shall maintain records of private sewage disposal systems cleaned and the location, method of septage disposal, and volume of septage disposed of for each trip. Such records shall be maintained for a period of five years and shall be made readily available upon request by the administrative authority.

[ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—68.7(455B) County obligations. The county boards of health shall enforce the standards and licensing requirements contained in this chapter and other referenced rules relating to the cleaning of private sewage disposal systems and disposal of septage from such facilities.

567—68.8(455B) Application sites and equipment inspections. All application sites specified on the waste management plan shall be inspected annually by an agent approved by the department to ensure that the sites meet the requirements for septage disposal and are properly managed. All tank trucks and related storage and handling facilities for septage shall be inspected annually to ensure compliance with these rules. The department may contract with other entities such as the local county health department to carry out the inspections. However, the department shall retain concurrent authority to determine inspection requirements.

567—68.9(455B) Standards for commercial cleaning of private sewage disposal systems.

68.9(1) *Vehicles, tanks and equipment.* For all vehicles, tanks and equipment used in the commercial cleaning of private sewage disposal systems, the licensee shall:

- a. Prevent the dripping, falling, spilling, leaking, or discharging of waste onto roads, rights-of-way or other public properties.
- b. Provide the equipment necessary for proper cleaning of private sewage disposal systems.
- c. Ensure proper construction and repair of cleaning equipment to allow easy cleaning and maintenance in an essentially rust-free and sanitary condition and appearance.
- d. If septage is to be land-applied, provide a mechanism for properly mixing lime with the septage or a means to incorporate or inject the septage.

68.9(2) Septic tank cleaning. Tanks shall be emptied of all waste. Sludge may be loosened by pumping liquid back into the tank or adding dilution water. The tank does not have to be washed out with fresh water; however, no more than four inches of waste shall be left in the bottom.

68.9(3) Miscellaneous.

- a. Any tanks or equipment used for hauling septage from private sewage disposal systems shall not be used for hauling hazardous or toxic wastes as defined in 567—Chapter 131 or other wastes detrimental to land application or wastewater treatment plants and shall not be used in a manner that would contaminate a potable water supply or endanger the food chain or public health.
- b. Pumps and associated piping shall be installed with watertight connections to prevent leakage.
- c. Agitation capability for use in cleaning private sewage disposal systems to disperse sludge and scum into the liquid for proper cleaning shall be provided.
- d. All vehicles shall display the license number (except for the year) assigned to the commercial septic tank cleaner with three-inch or larger letters and numbers on the side of the tank or vehicle.
- e. The name and address of the license holder shall be prominently displayed on the side of the tank or vehicle in letters at least three inches high.
- f. A direct connection shall not be made between a potable water source and the tank or equipment on the vehicle.

567—68.10(455B) Standards for disposal. Disposal of septage from private sewage disposal systems shall be carried out in accordance with the rules established by the department.

68.10(1) Waste from toilet units shall be disposed of by discharge to a publicly owned treatment works or other permitted wastewater treatment system with the treatment works owner's approval.

68.10(2) Septage from septic tanks or other types of private sewage disposal systems that normally discharge effluent for further treatment (such as mechanical/aerobic treatment tanks, siphon tanks or distribution boxes) shall be disposed of by utilizing one or more of the following methods:

- a. Septage shall be discharged to a publicly owned treatment works or other permitted wastewater treatment system with the treatment works owner's approval.
- b. Septage shall be discharged to permitted septage lagoons or septage drying beds with the septage system owner's approval.
- c. Septage shall be land-applied in accordance with the following requirements:
 - (1) The maximum application rate is 30,000 gallons of septage per acre of cropland per 365-day period. The nitrogen application rate shall be no more than is utilized by the crop. A crop capable of using the nitrogen applied must be grown and harvested from the site after application of the maximum annual allocation or, at a minimum, every third year.
 - (2) The following site restrictions shall be met when septage is applied to land:
 1. Septage shall not be applied to a lawn or a home garden.
 2. Septage shall not be applied to land where there is a bedrock layer or seasonal high water table within 3 feet of the soil surface. Determination of these confining layers may be ascertained by consulting the soil types noted in the county USDA soil surveys.
 3. Land application sites shall have soil pH maintained above 6.0, unless crops prefer soils with lower pH conditions. If the soil pH is below 6.0, it is acceptable to use agricultural lime to increase the pH to an acceptable level. Soil pH shall be measured and reported as part of the annual waste management plan.
 4. The septage shall not be applied to ground that has greater than 9 percent slope.

5. If application on frozen or snow-covered ground is necessary, it shall be limited to land areas of less than 5 percent slope and application rates of less than 2,500 gallons per acre per day.

6. Septage shall not be applied to land that is 35 feet or less from an open waterway. If septage is applied within 200 feet of a stream, lake, sinkhole or tile line surface intake located downgradient of the land application site, it shall be injected or applied to the surface and mechanically incorporated into the soil within 48 hours of application.

7. If the septage is applied to land subject to flooding more frequently than once in ten years, the septage shall be injected or shall be applied to the surface and mechanically incorporated into the soil within 48 hours. Information on which land is subject to flooding more frequently than once in ten years is available from the department.

8. Septage shall not be applied within 750 feet of an occupied residence, except the residence of the owner of the septic tank that was pumped, nor within 500 feet of a well.

9. Crop harvesting restrictions:

- Food crops with harvested parts that touch the septage/soil mixture and are totally above ground shall not be harvested for 14 months after application of domestic septage.

- Food crops with harvested parts below the surface of the land shall not be harvested for 38 months after application of domestic septage.

- Animal feed, fiber, and those food crops with harvested parts that do not touch the soil surface shall not be harvested for 30 days after application of the domestic septage. Animals shall not be allowed to graze on the land for 30 days after application of septage.

(3) One of the following vector attraction reduction requirements shall be met when septage is applied to land:

1. Septage shall be injected below the surface of the land. No significant amount of the septage shall be present on the land surface within one hour after the septage is injected.

2. Septage applied to the land surface shall be incorporated into the soil within six hours after application to or placement on the land.

3. Septage shall be stabilized by adding and thoroughly mixing sufficient alkaline material such as hydrated or quick lime to produce a mixture with a pH of 12. For example, adding and thoroughly mixing approximately 50 pounds of lime with each 1,000 gallons of septage is usually sufficient to bring the pH to 12 for 30 minutes. A minimum of 30 minutes of contact time shall be provided after mixing the lime with the septage prior to applying to land. Each container of septage shall be monitored for compliance by testing, using a pH meter or litmus paper, two representative samples of the batch of lime-treated domestic septage taken a minimum of 30 minutes apart to verify that the pH remains at 12 or greater for the minimum 30-minute time period.

(4) When septage is applied to land, the person who applies the septage shall develop the following information and shall retain the information for five years:

1. The location, by either street address or latitude and longitude, of each site on which septage is applied.

2. The number of acres and precise application area in each site on which septage is applied.

3. The gallons of septage applied each time.

4. The total gallons applied at each site to date for the year.

5. The date and time septage is applied to each site.

6. The rate, in gallons per acre, at which septage is applied to each site.

7. A description of how the vector attraction reduction requirements are met.

8. The following certification statement shall be provided with the records when the records are submitted to or requested by the department:

“I certify, under penalty of law, that the pathogen requirements and the vector attraction reduction requirements have been met. I am aware that there are significant penalties for false certification including the possibility of fine and imprisonment.”

(5) Other methods of stabilization may be acceptable if shown to be equivalent to 68.10(2)“c”(3)“3” above.

d. Septage shall be discharged (with owner approval) to a permitted sanitary landfill in accordance with 567—Chapters 102 and 103 and the following requirements:

(1) Septage shall be stabilized by adding and thoroughly mixing sufficient lime to produce a mixture with a pH of 12.

(2) A minimum of 30 minutes of contact time shall be provided after mixing the lime with the septage prior to discharging to the landfill.

[ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—68.11(455B) Standards for disposal of on-farm food processing wastewater. Disposal of on-farm food processing wastewater shall be carried out by utilizing one or more of the following methods:

68.11(1) On-farm food processing wastewater shall be discharged to a publicly owned treatment works or other permitted wastewater treatment system with the treatment works owner's approval.

68.11(2) On-farm food processing wastewater shall be discharged to a subsurface soil absorption system that is in compliance with 567—Chapter 69 and the United States Environmental Protection Agency's Underground Injection Control Program or other applicable regulations.

68.11(3) On-farm food processing wastewater shall be discharged through a disposal system that meets all of the following:

a. The disposal system is located on the same site as the on-farm processing operation.

b. The disposal system is constructed in conformance with a permit issued by the department in accordance with Iowa Code section 455B.183, implemented by 567—Chapter 64.

c. For a disposal system that discharges wastewater to a water of the United States, the system must be operated in conformance with a National Pollutant Discharge Elimination System permit issued by the department under Iowa Code section 455B.197.

68.11(4) Land application.

a. On-farm food processing wastewater may be land-applied if all of the following apply:

(1) The volume of wastewater produced by the on-farm processing operation is less than 1,500 gallons per day.

(2) The application rate does not exceed 30,000 gallons per acre per year.

(3) The application rate does not exceed 1,500 gallons per acre per day.

b. On-farm food processing wastewater shall be land-applied in accordance with 567—68.10(455B).

c. On-farm food processing operations that meet the requirements for land application in 68.11(4) shall not be required to obtain an operation permit as prescribed in 567—64.3(455B).

[ARC 0208C, IAB 7/11/12, effective 8/15/12]

These rules are intended to implement Iowa Code section 455B.172.

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CHAPTER 69
PRIVATE SEWAGE DISPOSAL SYSTEMS
[Prior to 7/1/83, Health Dept. Ch 12]
[Prior to 11/19/86, Water, Air and Waste Management[900] Ch 69]

567—69.1(455B) General.

69.1(1) Applicability. These rules are applicable only to private sewage disposal systems.

69.1(2) Definitions.

“Administrative authority” means the department and the local board of health as authorized by Iowa Code section 455B.172 and Iowa Code chapter 137.

“Aerobic treatment unit” means a disposal system employing bacterial action which is maintained by the utilization of air or oxygen and includes the aeration plant and equipment and the method of final effluent disposal.

“Approved” means accepted or acceptable under an applicable specification stated or cited in these rules or accepted by the administrative authority as suitable for the proposed use.

“Area drain” means a drain installed to collect surface or storm water from an open area of a building or property.

“Building drain” means that part of the lowest horizontal piping of a drainage system which receives the discharge from soil, waste, and other drainage pipes inside the walls of any building and conveys the same to the building sewer.

“Building sewer” means that part of the horizontal piping from the building wall to its connection with the main sewer or the primary treatment portion of a private sewage disposal system conveying the drainage of a building site.

“Chamber system” means a buried structure, typically with a domed or arched top, providing at least a 6-inch height of sidewall soil exposure below the invert of the inlet and creating a covered open space above a buried soil infiltrative surface.

“Conventional,” when used in reference to sewage treatment, means a soil absorption system involving a series of 2- to 3-foot-wide trenches filled with gravel 1 foot deep, containing a 4-inch-diameter rigid pipe or other alternative trench technologies to convey the sewage effluent.

“Distribution box” means a structure designed to accomplish the equal distribution of wastewater to two or more soil absorption trenches.

“Domestic sewage” or *“domestic wastewater”* means the water-carried waste products from residences, public buildings, institutions, or other buildings, including bodily discharges from human beings together with groundwater infiltration and surface water as may be present.

“Drip irrigation” means a form of subsurface soil absorption using shallow pressure distribution with low-pressure drip emitters.

“Drop box” means a structure used to divert wastewater flow into a soil absorption trench. When the trench is filled to a set level, the drop box then allows any additional wastewater not absorbed by that trench to flow to the next drop box or soil absorption trench.

“Dwelling” means any house or place used or intended to be used by humans as a place of residence.

“Expanded polystyrene (EPS) aggregate systems” means cylinders comprised of expanded polystyrene (EPS) synthetic aggregate contained in high-strength polyethylene netting. The cylinders are 12 inches in diameter and are produced both with and without a distribution pipe. Cylinders may be configured in a trench, bed, at-grade and mound applications to obtain the desired width, height and length. Cylinders containing a distribution pipe shall be connected end-to-end with an internal coupling device.

“Fill soil” means clean soil, free of debris or large organic material, which has been mechanically moved onto a site and has been in place for less than one year.

“Foundation drain” means that portion of a building drainage system which is provided to drain groundwater, not including any wastewater, from the outside of the foundation or over or under the basement floor and which is not connected to the building drain.

“Free access filter” means an intermittent sand filter constructed within the natural soil or above the ground surface, with access to the distributor pipes and top of the filter media for maintenance and media replacement.

“Gravel” means stone screened from river sand or quarried and washed free of clay and clay coatings. Concrete aggregate designated as Class II by the department of transportation is acceptable.

“Gravelless pipe system” means a soil absorption system comprised of 10-inch-diameter corrugated plastic pipe, perforated with holes on a 120-degree arc centered on the bottom, wrapped in a sheath of geotextile filter wrap, and installed level in a trench without gravel bedding or cover.

“Grease interceptor” means a watertight device designed to intercept and retain or remove grease and fatty substances. The device may be located inside (grease separator) or outside (grease tank or grease trap) a facility.

“Intermittent sand filter” means a bed of granular materials 24 to 36 inches deep underlain by graded gravel and collecting tile. Wastewater is applied intermittently to the surface of the bed through distribution pipes, and the bed is underdrained to collect and discharge the final effluent. Uniform distribution is normally obtained by dosing so as to utilize the entire surface of the bed. Filters may be designed to provide free access (open filters) or may be buried in the ground (buried filters or subsurface sand filters).

“Lake” means a natural or man-made impoundment of water with more than one acre of water surface area at the high water level.

“Limiting layer” means bedrock, seasonally high groundwater level, or any layer of soil with a stabilized percolation rate exceeding 60 minutes for the water to fall one inch.

“Mound system” means an aboveground soil absorption system used to disperse effluent from septic tanks in cases in which a seasonally high water table, high bedrock conditions, slowly permeable soils, or limited land areas prevent conventional subsurface soil absorption systems.

“Packed bed media filter” means a watertight structure filled with uniformly sized media that is normally placed over an underdrain system. The wastewater is dosed onto the surface of the media through a distribution network and is allowed to percolate through the media to the underdrain system. The underdrain collects the filtrate and discharges the final effluent.

“Percolation test” means a falling water level procedure used to determine the ability of soils to absorb primary treated wastewater. (See Appendix B.)

“Pond” means a natural or man-made impoundment of water with a water surface area of one acre or less at the high water level.

“Pretreated effluent” means septic tank effluent treated through aeration or other methods that, upon laboratory analysis, meets or exceeds a monthly average for biochemical oxygen demand (BOD) of 30 mg/L and total suspended solids (TSS) of 30 mg/L.

“Primary treatment unit” means a unit or system used to separate the floating and settleable solids from the wastewater before the partially treated effluent is discharged for secondary treatment.

“Private sewage disposal system” means a system which provides for the treatment or disposal of domestic sewage from four or fewer dwelling units or the equivalent of less than 16 individuals on a continuing basis, including domestic waste, whether residential or nonresidential, but not including industrial waste of any flow rate except as provided for in 567—68.11(455B). “Private sewage disposal system” includes, but is not limited to, septic tanks, holding tanks for waste, chemical toilets, impervious vault toilets and portable toilets.

“Professional soil analysis” means an alternative to the percolation test which depends upon a knowledgeable person evaluating the soil characteristics, such as color, texture, and structure, in order to determine an equivalent percolation or loading rate. A person performing a professional soil analysis shall demonstrate training and experience in soil morphology, such as testing absorption qualities of soil by the physical examination of the soil’s color, mottling, texture, structure, topography, and hillslope position.

“Qualified sampler,” for the purposes of collecting compliance effluent samples required under NPDES General Permit No. 4, means one of the following persons: a city or county environmental

health staff person; an Iowa-certified wastewater treatment operator; or an individual who has received training approved by the department to conduct effluent sampling.

“*Roof drain*” means a drain installed to receive water collecting on the surface of a roof and discharging into an area or storm drain system.

“*Secondary treatment system*” means a system which provides biological treatment of the effluent from septic tanks or other primary treatment units to meet minimum effluent standards as required in these rules and NPDES General Permit No. 4. Examples include soil absorption systems, media filters, aerobic treatment units, or other systems providing equivalent treatment.

“*Septage*” means the liquid and solid material pumped from a septic tank, cesspool, or similar domestic sewage treatment system, or from a holding tank, when the system is cleaned or maintained.

“*Septic tank*” means a watertight structure into which wastewater is discharged for solids separation and digestion (referred to as part of the closed portion of the treatment system).

“*Sewage sludge*” means any solid, semisolid, or liquid residue removed during the treatment of municipal wastewater or domestic sewage. “Sewage sludge” includes, but is not limited to, solids removed during primary, secondary, or advanced wastewater treatment, scum septage, portable toilet pumpings, Type III marine device pumpings as defined in 33 CFR Part 159, and sewage sludge products. “Sewage sludge” does not include grit, screenings, or ash generated during the incineration of sewage sludge.

“*Stream*” means any watercourse listed as a “designated use segment” in rule 567—61.3(455B) which includes any watercourse that maintains flow throughout the year or contains sufficient pooled areas during intermittent flow periods to maintain a viable aquatic community.

“*Subsurface sand filter*” means a system in which the effluent from the primary treatment unit is discharged into perforated pipes, filtered through a layer of sand, and collected by lower perforated pipes for discharge to the surface or to a subsurface soil absorption system. A subsurface sand filter is an intermittent sand filter that is placed within the ground and provided with a natural topsoil cover over the crown of the distribution pipes.

“*Subsurface soil absorption system*” means a system of perforated conduits connected to a distribution system, forming a series of subsurface, water-carrying channels into which the primary treated effluent is discharged for direct absorption into the soil (referred to as part of the open portion of the treatment system).

69.1(3) General regulations.

a. Connections to approved sewer system.

(1) No private sewage disposal system shall be installed, repaired, or rehabilitated where a publicly owned treatment works (POTW) is available or where a local ordinance requires connection to a POTW. The POTW may be considered as unavailable when such POTW, or any building or any exterior drainage facility connected thereto, is located more than 200 feet from any proposed building or exterior drainage facility on any lot or premises which abuts and is served by such POTW. Final determination of availability shall be made by the administrative authority.

(2) When a POTW becomes available within 200 feet, any building then served by a private sewage disposal system shall be connected to said POTW within a time frame or under conditions set by the administrative authority.

(3) When a POTW is not available, every building wherein persons reside, congregate, or are employed shall be provided with an approved private sewage disposal system.

(4) If a building is to be connected to an existing private sewage disposal system, that existing system shall meet the standards of these rules and be appropriately sized.

b. Discharge restrictions. It is prohibited to discharge any wastewater from private sewage disposal systems (except as permitted in this chapter) to any ditch, stream, pond, lake, natural or artificial waterway, county drain tile, surface water drain tile, or land drain tile, to the groundwater, or to the surface of the ground. Under no conditions shall effluent from private sewage disposal systems be discharged to any abandoned well, agricultural drainage well or sinkhole. Existing discharges to any of the above-listed locations or structures shall be eliminated by the construction of a system in compliance with the requirements of these rules.

c. Construction or alteration. All private sewage disposal systems constructed or altered after March 18, 2009, shall comply with this chapter. Alteration includes any changes that affect the treatment or disposal of the waste. Repair of existing components that does not change the treatment or disposal of the waste is exempt. However, the discharge restrictions in paragraph “b” above apply.

d. Abandonment. Private sewage disposal systems that are abandoned shall have the septic tank pumped, the tank lid crushed into the tank, and the tank filled with sand or soil.

69.1(4) Construction permit required. No private sewage disposal system shall be installed or altered as described in paragraph 69.1(3) “c” unless a construction permit issued by the administrative authority has been obtained. The installation shall be in accordance with these rules.

69.1(5) Permit by rule. This chapter is intended to act as a permit by rule for private sewage disposal systems. Activities in compliance with this chapter are permitted by the director for purposes of compliance with sections 455B.183 and 455B.186 of the Code of Iowa.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.2(455B) Time of transfer inspections.

69.2(1) Inspections required. Prior to any transfer of ownership of a building where a person resides, congregates, or is employed that is served by a private sewage disposal system, the sewage disposal system serving the building shall be inspected. In the event that weather or other temporary physical conditions prevent the certified inspection from being conducted, the buyer shall execute and submit a binding agreement with the county board of health to conduct a certified inspection of the private sewage disposal system at the earliest practicable time and to be responsible for any required modifications to the private sewage disposal system as identified by the certified inspection. In the event that all parties agree the existing private sewage disposal system will not pass inspection, the buyer may forego the inspection and execute a binding agreement with the local board of health to install a private sewage disposal system compliant with this rule at a time specified by the administrative authority. The inspection requirement applies to all types of ownership transfers not specifically exempted, including when a seller-financed real estate contract is signed.

a. Inspection exemptions. The following types of real estate transactions are exempt from the inspection requirement. However, the discharge restrictions in paragraph 69.1(3) “b” shall always apply.

(1) A transfer made pursuant to a court order, including but not limited to a transfer under Iowa Code chapter 633 or 633A, the execution of a judgment, the foreclosure of a real estate mortgage pursuant to Iowa Code chapter 654, the forfeiture of a real estate contract under Iowa Code chapter 656, a transfer by a trustee in bankruptcy, a transfer by eminent domain, or a transfer resulting from a decree for specific performance.

(2) A transfer to a mortgagee by a mortgagor or successor in interest who is in default, a transfer by a mortgagee who has acquired real property as a result of a deed in lieu of foreclosure or has acquired real property under Iowa Code chapter 654 or 655A, or a transfer back to a mortgagor exercising a right of first refusal pursuant to Iowa Code section 654.16A.

(3) A transfer by a fiduciary in the course of the administration of a decedent’s estate, guardianship, conservatorship, or trust.

(4) A transfer between joint tenants or tenants in common.

(5) A transfer made to a spouse or to a person in the lineal line of consanguinity of a person making the transfer.

(6) A transfer between spouses resulting from a decree of dissolution of marriage, a decree of legal separation, or a property settlement agreement which is incidental to the decree, including a decree ordered pursuant to Iowa Code chapter 598.

(7) A transfer in which the transferee intends to demolish or raze the building.

(8) A transfer of property with a system that was installed not more than two years prior to the date of the transfer.

(9) A deed arising from a partition proceeding.

(10) A tax sale deed issued by the county treasurer.

(11) A transfer for which consideration is \$500 or less.

(12) A deed between a family corporation, partnership, limited partnership, limited liability partnership, or limited liability company as defined in Iowa Code section 428A.2, subsection 15, and its stockholders, partners, or members for the purpose of transferring real property in an incorporation or a corporate dissolution or in the organization or dissolution of a partnership, limited partnership, limited liability partnership, or limited liability company under the laws of this state, where the deed is given for no actual consideration other than for shares or for debt securities of the family corporation, partnership, limited partnership, limited liability partnership, or limited liability company.

b. Inspection criteria. If a private sewage disposal system is failing to ensure effective wastewater treatment or is otherwise improperly functioning, the private sewage disposal system shall be renovated to meet current construction standards, as adopted by the department, either by the seller or, by agreement within a reasonable time period as determined by the administrative authority, by the buyer. If the private sewage disposal system is properly treating the wastewater and not creating an unsanitary condition in the environment at the time of inspection, the system is not required to meet current construction standards. However, the discharge restrictions in paragraph 69.1(3)“b” shall always apply.

c. Inspection validity. An inspection is valid for a period of two years for any ownership transfers during that period.

69.2(2) Certified time of transfer inspectors. Inspections shall be conducted by an inspector certified by the department. In order to be a certified time of transfer inspector, an individual shall have met the experience requirements, have successfully completed the inspection course and examination, and have been issued a current certificate by the department in accordance with this rule.

a. Experience requirements. In order to be certified by taking the inspection course and examination only, an individual must have at least two years' experience in the operation, installation, inspection, design or maintenance of private sewage disposal systems. Individuals lacking this experience must complete additional coursework before attending the inspection course with testing. The additional courses shall include, but not be limited to, “Onsite Basics 101” and “Alternative Systems” offered by the Onsite Wastewater Training Center of Iowa or courses determined by the department to be equivalent.

b. Examination application. A person wishing to take the examination necessary to become a certified inspector shall complete the Certified Time of Transfer Inspector Application, Form 542-0192. A listing of dates and locations of examinations is available from the department upon request. The application form requires the applicant to indicate pertinent educational background, training and past experience in providing private sewage disposal services. The completed application and the application fee shall be sent to Time of Transfer Inspector Certification, Iowa Department of Natural Resources, 502 E. 9th Street, Des Moines, Iowa 50319-0034. An application for examination must be received by the department at least 30 days prior to the date of the examination.

c. Application evaluation. The director may designate department personnel or an experience review committee to evaluate all applications for examination. A notification of the application review decision will be sent to the applicant prior to the examination date. The applicant shall have the right to dispute the application evaluation.

d. Certification. Applicants who successfully meet the department’s requirements will receive a written certification from the department. The department shall maintain a current listing of certified time of transfer inspectors. The list shall be available on the department’s Web site and shall be provided to county boards of health and other interested parties.

e. Fees. The following nonrefundable fees apply:

- (1) Examination fee. The fee for each examination shall be \$50.
- (2) Certification fee. The fee for inspector certification shall be \$75 for each one-half year of a two-year period from the date of issuance of the certification to June 30 of the next even-numbered year.
- (3) Certification renewal fee. The fee for certification renewal shall be \$300 for the two-year period.
- (4) Penalty fee. Rescinded IAB 7/11/12, effective 8/15/12.

f. Renewal period. All certificates shall expire on June 30 of even-numbered years and must be renewed every two years in order to maintain certification.

g. Renewal rights. Inspectors seeking renewal more than 45 days following expiration of the certificate shall lose the right to renew under the normal renewal process and must retake the inspector class and test to become recertified.

69.2(3) Continuing education.

a. CEU requirements. Continuing education units (CEUs) must be earned during each two-year period from April 1 of the even-numbered year until March 30 of the next even-numbered year. A certified inspector must earn 1.2 CEUs or 12 contact hours during each two-year period. Newly certified time of transfer inspectors (previously uncertified) who become certified after April 1 of a two-year period will not be required to earn CEUs until the next two-year period.

b. CEU approval. All activities for which CEU credit will be granted must be approved by an accredited college or university, an issuing agency, or the department and shall be related to private sewage disposal systems.

c. CEU reporting. It is the personal responsibility of the certified inspector to maintain a written record of and to notify the department of the CEUs earned during the period. The CEUs earned during the period shall be shown on the application for renewal.

69.2(4) Certificate renewal.

a. Certification period. All certificates shall expire on June 30 of even-numbered years and must be renewed every two years in order to stay effective.

b. Application for renewal. Renewal applications shall be submitted 60 days before the expiration date of the current certificate. Late applications or incomplete applications may lead to revocation of the certificate. Renewal of certificates will only be granted to inspectors in good standing.

c. CEUs. Only those certified inspectors fulfilling the continuing education requirements before the end of each two-year period (March 31) will be allowed to renew their certificates. The certificates of inspectors not fulfilling the continuing education requirements shall expire on June 30 of the even-numbered year.

d. Renewal fee. A renewal fee in the amount of \$300 must accompany the renewal application in order for the certificate to be renewed. Failure to submit the renewal fee on time may lead to revocation of the certificate.

69.2(5) Obligations of certified inspectors.

a. Certified inspectors shall conduct time of transfer inspections according to this rule.

b. Following an inspection, the inspection form and any attachments shall be provided to the county environmental health department for enforcement of any follow-up mandatory improvements to the system, to the department for record, and to the person ordering the inspection.

69.2(6) Disciplinary action.

a. Reasons for disciplinary action. Disciplinary action may be taken against a certified time of transfer inspector on any of the grounds specified in Iowa Code section 455B.219 and the following more specific grounds.

(1) Failure to use reasonable care or judgment or to apply knowledge or ability in performing the duties of a certified inspector.

(2) Failure to submit required records of inspection or other reports required under applicable permits or rules of the department, including failure to submit complete records or reports.

(3) Knowingly making any false statement, representation, or certification on any application, record, report or document required to be maintained or submitted under any applicable permit or rule of the department.

(4) Fraud in procuring a certificate.

(5) Professional incompetence.

(6) Knowingly making misleading, deceptive, untrue or fraudulent representations in the practice of the certified inspector's profession or engaging in unethical conduct or practice harmful or detrimental to the public. Proof of actual injury need not be established.

(7) Habitual intoxication or addiction to the use of drugs.

(8) Conviction of a felony related to the profession or occupation of the certified inspector. A copy of the record of conviction or plea of guilty shall be conclusive evidence.

- (9) Fraud in representations as to skill or ability.
- (10) Use of untruthful or improbable statements in advertisements.
- (11) Willful or repeated violations of the provisions of Iowa Code chapter 455B, division III.

b. Disciplinary sanctions. Disciplinary sanctions may include the following:

(1) Revocation of a certificate. Revocation may be permanent without chance of recertification or for a specified period of time.

(2) Partial revocation or suspension. Revocation or suspension of the practice of a particular aspect of the inspection of private sewage disposal systems may be imposed.

(3) Probation. Probation under specified conditions relevant to the specific grounds for disciplinary action may be imposed.

(4) Additional education, training, and examination requirements. Additional education, training, and reexamination may be required as a condition of reinstatement.

(5) Penalties. Civil penalties not to exceed \$1,000 may be assessed for causes identified in paragraph 69.2(6)“a” through the issuance of an administrative order.

c. Procedure.

(1) Initiation of disciplinary action. The department staff shall initiate a disciplinary action by conducting such lawful investigation as is necessary to establish a legal and factual basis for action. Written notice shall be given to a certified inspector against whom disciplinary action is being considered. The notice shall provide the certified inspector with 20 days to present any relevant facts and to indicate the certified inspector’s position in the matter.

(2) A certified inspector’s failure to communicate facts and positions relevant to the disciplinary investigation by the required date may be considered by the department when determining appropriate disciplinary action.

(3) If an agreement as to appropriate disciplinary action, if any, can be reached between the department and the certified inspector, a written stipulation and settlement shall be entered into. The stipulation and settlement shall recite the basic facts and violations alleged, any facts established by the certified inspector, and the reasons for the particular sanction imposed.

(4) If an agreement as to appropriate disciplinary action cannot be reached, the department may initiate formal disciplinary procedures through the issuance of a letter imposing such disciplinary sanction as the department has deemed appropriate. Service shall be provided by certified mail.

(5) A certified inspector may appeal any disciplinary sanction imposed by the department by filing a notice of appeal with the director within 30 days of receipt of the letter imposing disciplinary sanction. If an appeal is filed by the certified inspector, contested case proceedings shall be initiated by the department in accordance with 567—Chapter 7 and Iowa Code chapter 17A.

(6) Reinstatement of revoked certificates. Upon revocation of a certificate, application for certification may be allowed after two years from the date of revocation unless otherwise specified in accordance with paragraph 69.2(6)“b.” Any such applicant must meet all eligibility requirements pursuant to subrule 69.2(2) and successfully complete an examination and be certified in the same manner as a new applicant.

69.2(7) Procedures for noncompliance with child support order: Upon receipt of a certification of noncompliance with a child support obligation as provided in Iowa Code section 252J.7, the department will initiate procedures to deny an application for certification or renewal or to suspend a certification in accordance with Iowa Code section 252J.8(4). The department shall issue to the person by restricted, certified mail a notice of its intent to deny or suspend inspector certification based on receipt of a certificate of noncompliance. The suspension or denial shall be effective 30 days after receipt of the notice unless the person provides the department with a withdrawal of the certificate of noncompliance from the child support recovery unit as provided in Iowa Code section 252J.8(4)“c.” Pursuant to Iowa Code section 252J.8(4), the person does not have a right to a hearing before the department to contest the denial or suspension action under this subrule but may seek a hearing in district court in accordance with Iowa Code section 252J.9.

69.2(8) Inspection procedures. Inspections shall be conducted as follows:

a. Inspection form. The inspection shall be conducted using DNR Form 542-0191, Time of Transfer Inspection Report.

b. Record search. Prior to an inspection, the certified inspector shall contact the administrative authority to obtain any permits, as-built drawings or other information that may be available concerning the system being inspected. Information may also be obtained from service providers or the homeowner. If an as-built drawing is available, the system inspection shall verify that drawing. If no as-built drawing is available, the inspector shall develop an as-built drawing as part of the inspection.

c. Septic tank. At the time of inspection, any septic tank(s) existing as part of the sewage disposal system shall be opened and have the contents pumped out and disposed of according to 567—Chapter 68. In the alternative, the owner may provide evidence of the septic tank's being properly pumped out within three years prior to the inspection by a commercial septic tank cleaner licensed by the department which shall include documentation of the size and condition of the tank and its components at the time of such occurrence. If the septic tank(s) is opened, the condition of the tank and its components shall be documented and included in the final report.

d. Pumps and pump chambers. Pump chambers or vaults shall be opened for inspection, and the pump shall be tested to ensure proper operation.

e. Secondary treatment. Proof that a secondary treatment system is in place must be provided. This proof may include, but is not limited to:

(1) Opening a distribution box or uncovering a header pipe for a soil absorption system. Existing distribution boxes shall be opened for inspection.

(2) Verification of the existence of a sand filter by locating the vents and discharge pipe.

(3) Locating and opening the lid(s) of an advanced treatment unit.

(4) Absorption fields shall be probed to determine their condition. The condition of the fields shall be noted on the inspection report. The condition of the absorption field may also be determined with a hydraulic loading test.

f. Discharging systems. An effluent test shall be performed on any legally discharging private sewage disposal system. The effluent quality shall meet the requirements of NPDES General Permit No. 4 for CBOD₅ and TSS. The test results shall be included in the inspection report.

(1) The certified inspector shall report the location of the discharge point of a legally discharging private sewage disposal system and the discharge point's proximity to a perennial stream or drainage tile.

(2) Rescinded IAB 7/11/12, effective 8/15/12.

g. Packaged treatment units. An advanced treatment unit, such as an aerobic treatment unit, textile filter, peat filter or fixed activated sludge treatment system, shall be inspected according to the manufacturer's recommendations.

h. Other systems and system components. Private sewage disposal systems not mentioned above shall be inspected for code compliance, and an effluent sample shall be taken if applicable. Any components of the private sewage disposal system not mentioned above shall be inspected for proper function. Examples of other components include, but are not limited to, effluent screens, tertiary treatment systems, disinfection devices, alarms, control boxes and timers.

i. Inspection reports. Following an inspection, the inspection form and a narrative report describing the condition of the private sewage disposal system at the time of the inspection shall be provided to the county environmental health department, to the department for record, and to the person who ordered the inspection.

The certified inspector shall provide the completed inspection report to the county environmental health office within ten business days of the inspection date.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.3(455B) Site analysis.

69.3(1) Site evaluation. A site evaluation shall be conducted by the administrative authority prior to issuance of a construction permit. Consideration shall be given to, but not be limited to, the impact of the following: topography; drainage ways; terraces; floodplain; percent of land slope; location of property lines; location of easements; buried utilities; existing and proposed tile lines; existing, proposed

and abandoned water wells; amount of available area for the installation of the system; evidence of unstable ground; alteration (cutting, filling, compacting) of existing soil profile; and soil characteristics determined from a soil analysis, percolation tests, and soil survey maps if available.

a. Soil survey reports. During a site analysis and investigation, maximum use should be made of soil survey reports, which are available from USDA Natural Resources Conservation Service. A general identification of the percolation potential can be made from soil map units in Iowa. Verification of the soil permeability of the specific site must be performed.

b. Final inspections. All newly constructed private sewage disposal systems shall be inspected by the administrative authority before the system is backfilled or at a time prescribed by the administrative authority. A final as-built drawing shall be made as part of the final inspection.

c. Onsite wastewater tracking system. All pertinent information including, but not limited to, the site address, owner, type, date of installation, and as-built drawing of the private sewage disposal system shall be entered into the department's Web-based onsite wastewater tracking system.

69.3(2) Minimum distances. All private sewage disposal systems shall be located in accordance with the minimum distances shown in Table I.

Table I

Minimum Distance in Feet From	Closed Portion of Treatment System ⁽¹⁾	Open Portion of Treatment System ⁽²⁾
Private water supply well	50	100
Shallow public water supply well ⁽³⁾	200	400
Deep public water supply well ⁽⁴⁾	100	200
Groundwater heat pump borehole	50	100
Lake or reservoir	50	100
Stream or pond	25	25
Edge of drainage ditch	10	10
Dwelling or other structure	10	10
Property lines (unless a mutual easement is signed and recorded)	10	10
Other type of subsurface treatment system	5	10
Water lines continually under pressure	10	10
Suction water lines	50	100
Foundation drains or subsurface tiles	10	10

⁽¹⁾ Includes septic tanks, aerobic treatment units, fully contained media filters and impervious vault toilets.

⁽²⁾ Includes subsurface absorption systems, mound systems, intermittent sand filters, constructed wetlands, open bottom media filters and waste stabilization ponds.

⁽³⁾ "Shallow well" means a well located and constructed in such a manner that there is not a continuous layer of low-permeability soil or rock (or equivalent retarding mechanism acceptable to the department) at least 5 feet thick, the top of which is located at least 25 feet below the normal ground surface and above the aquifer from which water is to be drawn.

⁽⁴⁾ "Deep well" means a well located and constructed in such a manner that there is a continuous layer of low-permeability soil or rock at least 5 feet thick located at least 25 feet below the normal ground surface and above the aquifer from which water is to be drawn.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.4(455B) Requirements when effluent is discharged into surface water. All discharges from private sewage disposal systems which are discharged into, or have the potential to reach, any designated waters of the state or subsurface drainage tile shall be treated in a manner that will conform with the requirements of NPDES General Permit No. 4 issued by the department of natural resources, as referenced in 567—Chapter 64. Prior to the use of any system discharging to designated waters of the state or a subsurface drainage tile, a Notice of Intent to be covered by NPDES General Permit No. 4 shall be submitted to the department. Systems covered by this permit must meet all applicable requirements listed in the permit, including effluent sampling and monitoring.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.5(455B) Requirements when effluent is discharged above the ground surface.

69.5(1) All private sewage disposal systems that discharge above the ground surface shall be annually inspected to ensure proper operation.

69.5(2) Private sewage disposal systems that require a maintenance contract shall be inspected by a manufacturer’s certified technician.

69.5(3) Private sewage disposal systems that do not require a maintenance contract shall be visually inspected by a person with knowledge of the system for any malfunction and shall have the septic tank opened, inspected, and pumped if needed. A record of the inspection and any tank pumping shall be maintained and be made available to the administrative authority upon request.

69.5(4) No private sewage disposal system shall discharge to a state-owned natural or artificial lake, an outstanding Iowa water or an outstanding national water as defined in 567—subrule 61.2(2) unless authorized by an individual NPDES permit.
 [ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.6(455B) Requirements when effluent is discharged into the soil. No septage or wastewater shall be discharged into the soil except in compliance with the requirements contained in this chapter.
 [ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.7(455B) Building sewers.

69.7(1) *Location and construction.*

a. The types of construction and distances as shown in Table II shall be maintained for the protection of water supplies. The distances shall be considered minimum distances and shall be increased where possible to provide better protection.

Table II

Sewer Construction	Distance in Feet From Well Water Supply	
	Private	Public
1. Schedule 40 plastic pipe (or SDR 26 or stronger) with approved-type joints or cast-iron soil pipe (extra heavy or centrifugally cast) with joints of preformed gaskets.	10	25
2. Sewer pipe installed to remain watertight and root-proof.	50	75

b. Under no circumstances shall a well suction line pass under a building sewer line.

69.7(2) *Requirements for building sewers.*

a. *Type.* Building sewers used to conduct wastewater from a building to the primary treatment unit of a private sewage disposal system shall be constructed of Schedule 40 plastic pipe (or SDR 26 or stronger) with solvent-weld or bell-and-gasket-type joints or shall be constructed of cast iron with integral bell-and-gasket-type joints.

b. *Size.* Such building sewers shall not be less than 4 inches in diameter.

c. *Grade.* Such building sewers shall be laid to the following minimum grades:

- 4-inch sewer 12 inches per 100 feet
- 6-inch sewer 8 inches per 100 feet

69.7(3) *Cleanouts.*

a. *Spacing.* A cleanout shall be provided where the building sewer leaves the house and at least every 100 feet downstream to allow for rodding.

b. *Change of direction or grade.* An accessible cleanout shall be provided at each change of direction or grade if the change exceeds 45 degrees.

69.7(4) Grease interceptors.

a. Applicability. Grease interceptors shall be provided for kitchen flows at restaurants, nursing homes, schools, hospitals and other facilities from which grease can be expected to be discharged.

b. Installation. Grease interceptors shall be installed on a separate building sewer serving kitchen flows into which the grease will be discharged. The discharge from the grease interceptor must flow to a properly designed septic tank or to a building sewer and then to the septic tank.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.8(455B) Primary treatment—septic tanks.**69.8(1) General requirements.**

a. Septic tank required. Every private sewage disposal system shall have as a primary treatment unit a septic tank as described in this rule. All wastewater from the facility serviced shall discharge into the septic tank (except as noted in paragraph “d” below).

b. Easements. No septic tank shall be located upon property under ownership different from the ownership of that property or lot upon which the wastewater originates unless easements to that effect are legally recorded and approved by the proper administrative authority.

c. Effluent discharge requirements. All septic tank effluent shall discharge into a secondary treatment system in compliance with this chapter or into another system approved by the administrative authority according to rule 567—69.21(455B).

d. Prohibited wastes. Septic tanks shall not be used for the disposal of chemical wastes or grease in quantities which might be detrimental to the bacterial action in the tank or for the disposal of drainage from roof drains, foundation drains, or area drains.

69.8(2) Capacity.

a. Minimum capacity. The minimum liquid-holding capacity shall be as specified in the following table (capacity may be obtained by using one or more tanks):

Up to and including 3-bedroom homes	1,250 gal.
4-bedroom homes	1,500 gal.
5-bedroom homes	1,750 gal.
6-bedroom homes	2,000 gal.

b. Other domestic waste systems. In the event that an installation serves more than a 6-bedroom home or its equivalent, or serves a facility other than a house and serves the equivalent of fewer than 16 individuals on a continuing basis, approval of septic tank capacity and design must be obtained from the administrative authority. Minimum septic tank liquid-holding capacity shall be two times the estimated daily sewage flow.

c. Determination of flow rates. Residential wastewater flows are based on 150 gallons per bedroom per day. For wastewater flow rates for nonresidential and commercial domestic waste applications serving the equivalent of fewer than 16 individuals on a continuing basis, refer to Appendix A.

d. Minimum depth. The minimum liquid-holding depth in any compartment shall be 40 inches.

e. Maximum depth. The maximum liquid-holding depth for calculating capacity of the tank shall not exceed 6½ feet.

f. Dimensions. The interior length of a septic tank should not be less than 5 feet and shall be at least 1½ times the width (larger length-to-width ratios are preferred). No tank or compartment shall have an inside width of less than 2 feet. The minimum inside diameter of a vertical cylindrical septic tank shall be 5 feet.

69.8(3) Construction details.

a. Fill soil. Any septic tank placed in fill soil shall be placed upon a level, stable base that will not settle.

b. Compartmentalization. Every septic tank shall be divided into two compartments (compartmentalization may be obtained by using more than one tank) as follows:

(1) The capacity of the influent compartment shall not be less than one-half or more than two-thirds of the total tank capacity.

(2) The capacity of the effluent compartment shall not be less than one-third or more than one-half of the total tank capacity.

c. Inlet/outlet. The invert of the inlet pipe shall be a minimum of 2 inches and a maximum of 4 inches higher than the invert of the outlet pipe.

d. Baffles.

(1) Four-inch-diameter Schedule 40 plastic pipe tees shall be used as inlet and outlet baffles. Inlet tees shall extend at least 6 inches above and 8 inches below the liquid level of the tank. The inlet tee shall extend below the liquid level no more than 20 percent of the liquid depth. The outlet tee shall extend above the liquid level a distance of at least 6 inches and below the liquid level a distance of at least 15 inches but no more than 30 percent of the liquid depth. A minimum 2-inch clearance between the top of the inlet and outlet tees and the bottom of the tank lid shall be provided. A horizontal separation of at least 36 inches shall be provided between the inlet baffle and the outlet baffle in each compartment. Outlet baffles shall be fitted with, or replaced by, an approved effluent screen. All effluent screens shall be certified by an ANSI-accredited third-party certifier to meet National Sanitation Foundation Standard 46, including appendices, or other equivalent testing as determined by the department. Effluent screens require periodic inspection and cleaning to ensure their continued proper operation.

(2) A horizontal slot 4 inches by 6 inches, or two suitably spaced 4-inch-diameter holes in the tank partition, may be used instead of a tee or baffle. The top of the slot or holes shall be located below the water level a distance of one-third the liquid depth. A ventilation hole or slot, located at least 8 inches above the liquid level, shall be provided in the partition.

e. Access.

(1) Access necessary for adequate inspection, operation, and maintenance must be provided to all parts of septic tanks.

(2) An access opening shall be provided at each end of the tank over the inlet and outlet. These openings shall be at least 18 inches in the smallest dimension.

(3) Watertight risers with a minimum diameter of 18 inches shall be installed to bring the access openings to the ground surface. Risers shall be secured using stainless steel fasteners of sufficient complexity, locking devices, concrete lids of sufficient weight, or another device approved by the administrative authority to deter tampering.

69.8(4) Construction.

a. Materials. Tanks shall be constructed of watertight poured concrete, fiberglass or plastic resistant to corrosion or decay and shall be designed so that the tanks, whether full or empty, will not collapse or rupture when subjected to anticipated earth and hydrostatic pressures. Metal tanks are prohibited.

b. Watertight tanks. Tanks shall be watertight. Prior to approving a tank, the administrative authority may ask for proof that a tank is watertight.

c. Dividers. Tank divider walls and divider wall supports shall be constructed of heavy, durable plastic, fiberglass, concrete or other similar corrosion-resistant materials approved by the administrative authority.

d. Inlet and outlet ports. Inlet and outlet ports of pipe shall be constructed of heavy, durable Schedule 40 PVC plastic sanitary tees or other similar approved corrosion-resistant material.

69.8(5) Wall thickness. Minimum wall thickness for tanks shall conform to applicable IAPMO¹ standards or the following specifications:

Poured concrete	6 inches thick
Poured concrete, reinforced	4 inches thick
Special concrete mix, vibrated and reinforced	2.5 inches thick
Fiberglass or plastic	.25 inches thick

¹International Association of Plumbing and Mechanical Officials

69.8(6) Concrete specifications. Concrete used in precast septic tank construction shall have a maximum water-to-cement ratio of 0.45. Cement content shall be at least 650 pounds per cubic yard. Minimum compressive strength (f_c) shall be 4,000 psi (28 Mpa) at 28 days of age. The use of ASTM C150 Type II cement or the addition of silica fume or Class F fly ash is recommended.

69.8(7) Tank bottoms. Septic tank bottoms shall conform to the specifications set forth in subrule 69.8(5) for septic tank walls, except that special mix concrete shall be at least 3 inches thick.

69.8(8) Tank tops. Concrete or masonry septic tank tops shall be a minimum of 4 inches in thickness and shall be reinforced with $\frac{3}{8}$ -inch reinforcing rods in a 6-inch grid or equivalent. Fiberglass or plastic tank tops shall be a minimum of $\frac{1}{4}$ inch in thickness and shall have reinforcing and be of ribbed construction.

69.8(9) Reinforcing steel placement. The concrete cover for reinforcing bars, mats, or fabric shall not be less than 1 inch.

69.8(10) Bedding. Fiberglass or plastic tanks shall be bedded according to the manufacturer's specifications. Provisions should be made to prevent flotation of the tanks when they are empty.

69.8(11) Connecting pipes.

a. *Minimum diameter.* The pipes connecting septic tanks installed in series and at least the first 5 feet of pipe on the effluent side of the last tank shall be a minimum of 4-inch-diameter Schedule 40 plastic.

b. *Tank connections.* All inlet and outlet connections at the septic tanks shall be made by self-sealing gaskets cast into the concrete or formed into the plastic or fiberglass.

c. *Joints.* All joints in connecting Schedule 40 plastic pipe shall be approved plastic pipe connections such as solvent-welded or compression-type gaskets.

d. *Pipe in unstable ground.* Schedule 40 plastic pipe shall be used extending across excavations or unstable ground to at least 2 feet beyond the point where the original ground has not been disturbed in septic tank installations. If the excavation spanned is more than 2 feet wide, it must be filled with sand or compacted fill to provide a firm bed for the pipe. The first 12 inches of backfill over the pipe shall be applied in thin layers, using material free from stones, boulders, large frozen chunks of earth or any similar material that would damage or break the pipe.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.9(455B) Secondary treatment—subsurface soil absorption systems. Subsurface soil absorption systems are the best available treatment technology and shall always be used where possible.

69.9(1) General requirements.

a. *Locations.* All subsurface soil absorption systems shall be located on the property to maximize the vertical separation distance from the bottom of the absorption trench to the seasonal high groundwater level, bedrock, hardpan or other confining layer, but under no circumstances shall this vertical separation be less than 3 feet.

b. *Soil evaluation.* A percolation test or professional soil analysis is required before any soil absorption system is installed.

(1) *Percolation test.* The percolation test procedure is outlined in Appendix B.

(2) *Alternative analysis.* If a professional soil analysis is performed, soil characteristics such as soil content, color, texture, and structure shall be used to determine a loading rate.

(3) *Acceptable percolation rate.* An area is deemed suitable for conventional soil absorption if the average percolation rate is 60 minutes per inch or less and greater than 1 minute per inch. However, if an alternative soil absorption system is proposed (e.g., mound system), then the percolation test should be extended to determine whether a percolation rate of 120 minutes per inch is achieved.

(4) *Confining layer determination.* An additional test hole 6 feet in depth or to rock, whichever occurs first, shall be provided in the center of the proposed absorption area to determine the location of groundwater, rock formations or other confining layers. This 6-foot test hole may be augered the same size as the percolation test holes or may be made with a soil probe.

c. *Groundwater.* If the seasonal high groundwater level is present within 3 feet of the trench bottom final grade and cannot be successfully lowered by subsurface tile drainage, the area shall

be classified as unsuitable for the installation of a standard subsurface soil absorption system. The administrative authority shall be consulted to determine an acceptable alternative method of wastewater treatment.

d. Site limitations. In situations where specific location or site characteristics would appear to prohibit installation of a soil absorption system, design modifications which could overcome such limitations may be approved by the administrative authority. Examples of such modifications could be the installation of subsurface drainage, use of shallow or at-grade trenches, drip irrigation, or mound systems or use of pretreated effluent.

e. Prohibited drainage. Roof, foundation and storm drains shall not discharge into or upon subsurface absorption systems. Nothing shall enter the subsurface absorption system which does not first pass through the septic tank.

f. Prohibited construction. There shall be no construction of any kind, including driveways, covering the septic tank, distribution box or absorption field of a private sewage disposal system. Vehicle access should be infrequent, primarily limited to vegetation maintenance.

g. Driveway crossings. Connecting lines under driveways shall be constructed of Schedule 40 plastic pipe or equivalent and shall be protected from freezing.

h. Easements. No wastewater shall be discharged upon any property under ownership different from the ownership of the property or lot upon which the wastewater originates unless easements to that effect are legally recorded and approved by the administrative authority.

69.9(2) Sizing requirements.

a. Percolation and soil loading charts. Table IIIa provides a correlation between percolation rates and soil loading rates. Table IIIb provides soil loading rates based upon soil texture and structure. Table IIIa and Table IIIb shall be used to determine the appropriate soil loading rate. Table IIIc specifies linear feet of lateral trenches required based upon the soil loading rate, wastewater flow rate, and trench width. Table IIId provides a method to determine the size of an absorption bed. Absorption beds (Table IIId) shall not be used except when the lot size limitations preclude the installation of a lateral trench system. Further details concerning limitations of this alternative shall be obtained from the administrative authority before authorization for installation is requested.

b. Unsuitable absorption. Conventional subsurface soil absorption trenches shall not be installed in soils that have a percolation rate less than 1 minute per inch or greater than 60 minutes per inch. Plans for an alternative method of wastewater treatment shall be submitted to the administrative authority for approval prior to construction.

Table IIIa
Maximum Soil Application Rates Based Upon Percolation Rates
Monthly Averages

Percolation Rate (minutes per inch)	Septic Tank Effluent ⁽¹⁾	Pretreated Effluent
	BOD ₅ 30 mg/L - 220 mg/L TSS 30 mg/L - 150 mg/L (gals/sq ft/day) ⁽²⁾	BOD ₅ ≤ 30 mg/L TSS ≤ 30 mg/L (gals/sq ft/day)
0 to 5	1.2	1.6
Fine sands	0.5	0.9
6 to 10	0.8 – 0.6	1.2
11 to 29	0.6 – 0.5	0.9
30 to 45	0.5 – 0.4	0.7
46 to 60	0.4 – 0.2	0.5
61 to 120	0.0	0.3
Greater than 120	0.0	0.0

NOTE: "BOD" means biochemical oxygen demand. "TSS" means total suspended solids.

⁽¹⁾ Typical waste strengths for domestic waste. Pretreatment should be considered for waste of higher strength.

⁽²⁾ Percolation rates and soil loading rates do not precisely correlate; therefore, a range is provided.

Table IIIb

Maximum Soil Loading Rates Based Upon Soil Evaluations in Gallons per Square Foot per Day (gal/ft²/day) for Septic Tank Effluent. Values in () are for secondary treated effluent.

Soil Texture	Single Grain	Massive	Structure Granular, Blocky, or Prismatic			Platy	
			Weak	Moderate	Strong	Weak	Moderate to Strong
Coarse sand and gravel	1.2 (1.6)	X	1.2 (1.6)	X	X	1.2 (1.6)	X
Medium sands	0.7 (1.4)	X	0.7 (1.4)	X	X	0.7 (1.4)	X
Fine sands	0.5 (0.9)	X	0.5 (0.9)	X	X	0.5 (0.9)	X
Very fine sands*	0.3 (0.5)	X	0.3 (0.5)	X	X	0.3 (0.5)	X
Sandy loam	X	0.3 (0.5)	0.45 (0.7)	0.6 (1.1)	0.65 (1.2)	0.4 (0.6)	0.3 (0.5)
Loam	X	0.4 (0.6)	0.45 (0.7)	0.5 (0.8)	0.55 (0.8)	0.4 (0.6)	0.3 (0.5)
Silty loam	X	NS	0.4 (0.6)	0.5 (0.8)	0.5 (0.8)	0.3 (0.5)	0.2 (0.3)
Clay loam	X	NS	0.2 (0.3)	0.45 (0.7)	0.45 (0.7)	0.1 (0.2)	0.1 (0.2)
Silty clay loam	X	NS	0.2 (0.3)	0.45 (0.7)	0.45 (0.7)	NS	NS

NOTE: "X" means not found in nature. "NS" means not suitable for soil absorption.

* Flow rates are difficult to determine for some very fine sands; experience may provide better information and flow rates.

Table IIIc

Minimum Length of Absorption Trenches in Feet

	2 bedroom 300 gal.		3 bedroom 450 gal.		4 bedroom 600 gal.		5 bedroom 750 gal.		6 bedroom 900 gal.	
	2'	3'	2'	3'	2'	3'	2'	3'	2'	3'
Soil loading rate gal/ft ²										
0.1	Not suitable for soil absorption trenches									
0.2	750	500	1125*	750	1500*	1000*	1875*	1250*	2250*	1500*
0.3	500	333	750	500	1000*	666	1250*	833*	1500*	1000*
0.4	375	250	562	375	750	500	938*	625	1125*	750
0.5	300	200	450	300	600	400	750	500	900*	600
0.6	250	167	375	250	500	333	625	417	750	500
0.7	214	143	321	214	428	286	536	357	643	429
0.8	188	125	281	188	375	250	469	312	562	375
0.9	167	111	250	167	333	222	417	278	500	333
1.0	150	100	225	150	300	200	375	250	450	300
1.1	136	91	205	136	273	182	341	227	409	273
1.2	125	84	188	125	250	167	313	208	375	250

* Requires pressure distribution (pump)

Table III d
Alternative Option for Use of Absorption Bed*

Percolation Rate min./inch	Absorption Area/Bedroom sq. ft.	Loading Rate/Day gal./sq. ft.
1 – 5	300	.5
6 – 15	400	.375
16 – 30	600	.25

*Absorption beds may only be used when site space restrictions require and shall not be used when the soil percolation rate exceeds 30 min./inch.

69.9(3) Construction details for all soil absorption trenches.

a. Depth. Soil absorption trenches shall not exceed 36 inches in depth unless authorized by the administrative authority, but a shallower trench bottom depth of 18 to 24 inches is recommended. Not less than 6 inches of porous soil shall be provided over the laterals. The minimum separation between trench bottom and groundwater, rock formation or other confining layers shall be 36 inches even if extra rock is used under the pipe.

b. Length. No soil absorption trench shall be greater than 100 feet long.

c. Separation distance. At least 6 feet of undisturbed soil shall be left between each trench edge on level sites. The steeper the slope of the ground, the greater the separation distance should be. Two feet of separation distance should be added for each 5 percent increase in slope from level.

d. Grade. The trench bottom should be constructed level from end to end. On sloping ground, the trench shall follow a uniform land contour to maintain a minimum soil cover of 6 inches and a level trench bottom.

e. Compaction. There shall be minimum use or traffic of heavy equipment on the area proposed for soil absorption. In addition, it is prohibited to use heavy equipment on the bottom of the trenches in the absorption area.

f. Fill soil. Soil absorption systems shall not be installed in fill soil. Disturbed soils which have stabilized for at least one year shall require a recent percolation test or soil analysis.

g. Bearing strength. Soil absorption systems shall be designed to carry loadings to meet AASHTO H-10 standards.

h. Soil smearing. Soils with significant clay content should not be worked when wet. If soil moisture causes sidewall smearing, the installation should be discontinued until conditions improve.

69.9(4) Gravel systems.

a. Gravel. A minimum of 6 inches of clean, washed river gravel, free of clay and clay coatings, shall be laid below the distribution pipe, and enough gravel shall be used to cover the pipe. This gravel shall be of such a size that 100 percent of the gravel will pass a 2½-inch screen and 100 percent will be retained on a ¾-inch screen. Limestone or crushed rock is not recommended for soil absorption systems; however, if used, it shall meet the following criteria:

(1) *Abrasion loss.* The percent wear, as determined in accordance with the AASHTO T 96, Grading C, shall not exceed 40 percent.

(2) *Freeze and thaw loss.* When gravel is subjected to the freezing and thawing test, Iowa DOT Materials Laboratory Test Method 211, Method A, the percentage loss shall not exceed 10 percent.

(3) *Absorption.* The percent absorption, determined in accordance with Iowa DOT Materials Laboratory Test Method 202, shall not exceed 3 percent.

b. Trench width. Soil absorption trenches for gravel systems shall be a minimum of 24 inches and a maximum of 36 inches in width at the bottom of the trench.

c. Grade. The distribution pipes shall be laid with a minimum grade of 2 inches per 100 feet of run and a maximum grade of 6 inches per 100 feet of run, with a preference given to the lesser slope.

d. Pipe. Distribution pipe shall be PVC rigid plastic meeting ASTM Standard 2729 or other suitable material approved by the administrative authority. The inside diameter shall be not less than 4 inches, with perforations at least ½ inch and no more than ¾ inch in diameter, spaced no more than 40

inches apart. Two rows of perforations shall be provided located 120 degrees apart along the bottom half of the tubing (each 60 degrees up from the bottom centerline). The end of the pipe in each trench shall be sealed with a watertight cap unless, on a level site, a footer is installed connecting the trenches together. Coiled perforated plastic pipe shall not be used.

e. Gravel cover. Unbacked, rolled, 3½-inch-thick fiberglass insulation, untreated building paper, synthetic drainage fabric, or other approved material shall be laid so as to separate the gravel from the soil backfill.

69.9(5) Gravelless pipe systems.

a. Application. Gravelless subsurface soil absorption systems may be used as an alternative to conventional 4-inch pipe placed in gravel-filled trenches. However, these systems shall not be used in areas where conventional systems would not be allowed due to poor permeability, high groundwater, or insufficient depth to bedrock.

b. Installation. The manufacturer's specifications and installation procedures shall be adhered to.

c. Material. The 10-inch I.D. corrugated polyethylene tubing used in gravelless systems shall meet the requirements of ASTM F667, Standard Specification for Large Diameter Corrugated Polyethylene Tubing.

d. Perforations. Two rows of perforations shall be located 120 degrees apart along the bottom half of the tubing (each 60 degrees up from the bottom centerline). Perforations shall be cleanly cut into each inner corrugation along the length of the tubing and should be staggered so that there is only one hole in each corrugation.

e. Top marking. The tubing should be visibly marked to indicate the top of the pipe.

f. Filter wrap. All gravelless drainfield pipe shall be encased, at the point of manufacture, with a geotextile filter wrap specific to this purpose.

g. Trench width. The trench width for the gravelless system shall be 24 inches.

h. Length of trench. The total length of absorption trench for a 10-inch gravelless pipe installation shall be the same as given in Table IIIc for a 2-foot-wide conventional soil absorption trench.

69.9(6) Chamber systems.

a. Application. Chamber systems may be used as an alternative to conventional 4-inch pipe placed in gravel-filled trenches. However, chamber systems shall not be used in areas where conventional systems would not be allowed due to poor permeability, high groundwater, or insufficient depth to bedrock.

b. Installation. The manufacturer's specifications and installation procedures shall be adhered to.

c. Length of trench. The total length of soil absorption trench for chambers 15 to 22 inches wide shall be the same as given in Table IIIc for a 2-foot-wide conventional soil absorption trench. Chambers 33 inches wide or greater shall be sized as given in Table IIIc for a 3-foot-wide conventional soil absorption trench.

d. Sidewall. The chambers shall have at least 6 inches of sidewall effluent soil exposure height below the invert of the inlet.

69.9(7) Expanded polystyrene (EPS) aggregate system.

a. Application. EPS aggregate systems may be used as an alternative to conventional 4-inch pipe placed in gravel-filled trenches. However, EPS aggregate systems shall not be used in areas where conventional systems would not be allowed due to poor permeability, high groundwater, or insufficient depth to bedrock.

b. Installation. The manufacturer's specifications and installation procedures shall be adhered to.

c. Length of trench. The total length of soil absorption trench for 12-inch EPS aggregate bundles shall be the same as given in Table IIIc for a 2-foot-wide conventional soil absorption trench. Twelve-inch EPS aggregate bundles 33 inches wide or greater shall be sized as given in Table IIIc for a 3-foot-wide conventional soil absorption trench.

d. Gravel cover. Unbacked, rolled, 3½-inch-thick fiberglass insulation, untreated building paper, synthetic drainage fabric, or other approved material shall be laid so as to separate the EPS aggregate from the soil backfill.

69.9(8) Gravity distribution. Dosing is always recommended and preferred to improve distribution, improve treatment and extend the life of the system.

a. On a hillside, septic tank effluent may be serially loaded to the soil absorption trenches by drop boxes or overflow piping (rigid sewer pipe). Otherwise, effluent shall be distributed evenly to all trenches by use of a distribution box or commercial distribution regulator approved by the administrative authority.

b. Design. When a distribution box is used, it shall be of proper design and installed with separate watertight headers leading from the distribution box to each lateral. Header pipes shall be rigid PVC plastic pipe meeting ASTM Standard 2729 or equivalent.

c. Height of outlets. The distribution box shall have outlets at the same level at least 4 inches above the bottom of the box to provide a minimum of 4 inches of water retention in the box.

d. Baffles. There shall be a pipe tee or baffle at the inlet to break the water flow.

e. Unused outlets. All unused outlet holes in the box shall be securely closed.

f. Materials. All distribution boxes shall be constructed of corrosion-resistant rigid plastic materials.

g. Level outlets. All outlets of the distribution box shall be made level. A 4-inch cap with an offset hole approximately 2½ inches in diameter shall be installed on each outlet pipe. These caps shall be rotated until all outlets discharge at the same elevation. Equivalent leveling devices may be approved by the county board of health.

h. Equal length required. The soil absorption area serviced by each outlet of the distribution box shall be equal.

69.9(9) Dosing systems.

a. Pump systems.

(1) Pump and pit requirements. In the event the effluent from the septic tank outlet cannot be discharged by gravity and the proper lateral depths still maintained, the effluent shall discharge into a watertight pump pit with an inside diameter of not less than 24 inches, equipped with a tight-fitting manhole cover at grade level. The pump shall be of a submersible type of corrosion-resistant material.

(2) Pump setting. The pump shall be installed in the pump pit in a manner that ensures ease of service and protection from frost and settled sludge. The pump shall be set to provide a dosing frequency of approximately four times a day based on the maximum design flow. No onsite electrical connections shall be located in the pump pit. These connections shall be located in an exterior weatherproof box.

(3) Pressure line size. The pressure line from the pump to the point of discharge shall not be smaller than the outlet of the pump it serves.

(4) Drainage. Pressure lines shall be installed to provide total drainage between dosing to prevent freezing or shall be buried below frost level up to the distribution box.

(5) High water alarm. Pump pits shall be equipped with a sensor set to detect if the water level rises above the design high water level when the pump fails. This sensor shall activate an auditory or visual alarm to alert the homeowner that repairs are required.

(6) Discharge point. The effluent shall discharge under pressure into a distribution box or may be distributed by small-diameter pipes throughout the entire absorption field.

b. Dosing siphons. Dosing siphons may also be used. The manufacturer's specifications shall be adhered to for installation. Similar dosing volumes and frequencies are recommended. Dosing siphons require periodic cleaning to ensure their continued proper operation.

c. Filtered pump vaults. A filtered pump vault is a device that is installed in a septic tank and houses a pump and screens effluent until it is pumped. Filtered pump vaults may be used when dosing volume is less than 50 gallons. Filtered pump vaults require periodic inspection and cleaning to ensure their continued proper operation.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.10(455B) Mound systems.**69.10(1) General requirements.**

a. Mound systems shall be permitted only after a thorough site evaluation has been made and landscaping, dwelling placement, effect on surface drainage, and general topography have been considered.

b. Mound systems shall not be utilized on sites subject to flooding with a ten-year or greater frequency.

c. Mound systems shall not be utilized on soils where the high groundwater level, impermeable bedrock or soil strata having a percolation rate exceeding 120 minutes per inch occur within 12 inches of natural grade or where creviced bedrock occurs within 20 inches of natural grade.

d. Mound systems shall be constructed only upon undisturbed naturally occurring soils or where a soil analysis has determined the site is suitable.

e. Mound systems shall be located in accordance with the distances specified in Table I as measured from the outer edge of the sand in the mound.

f. No buildings, driveways or other surface or subsurface obstructions shall be permitted within 50 feet on the down-gradient side of the mound when the mound is constructed on a slope greater than 5 percent. No future construction shall be permitted in this effluent disposal area as long as the mound is in use.

g. Specifications given in these rules for mounds are minimal and may not be sufficient for all applications. Technical specifications are changing with experience and research. Other design information beyond the scope of these rules may be necessary to properly design a mound system.

69.10(2) Material for mound fill.

a. The mound shall be constructed using clean, medium-textured sand, sometimes referred to as concrete sand. The sand size shall be such that at least 25 percent by weight shall have a diameter between 2.0 and 0.25 mm; less than 35 percent by weight, a diameter between 0.25 and 0.05 mm; and less than 5 percent by weight, a diameter between 0.05 and 0.002 mm.

b. Rock fragments larger than 1/16 inch (2.0 mm) shall not exceed 15 percent by weight of the material used for mound fill.

69.10(3) Construction details.

a. There shall be a minimum of 3 feet of fill material and undisturbed naturally occurring soils between the bottom of the washed gravel and the highest elevation of the limiting conditions defined in paragraph 69.10(1)“c.”

b. Gravel shall meet the requirements specified in paragraph 69.9(4)“a.”

c. From 1 to 2 feet of medium-textured sand (depending upon the underlying soil depth, see paragraph 69.10(3)“a”) must be placed between the bottom of the gravel and the top of the plowed surface of the naturally occurring soil.

d. Mound systems shall utilize an absorption bed distribution piping design. The bed shall be installed with the long dimension parallel to the land contour. Systems on steep slopes with slowly permeable soils should be narrow to reduce the possibility of toe seepage.

e. Minimum spacing between distribution pipes shall be 4 feet, and a minimum of 3 feet shall be maintained between any trench and the sidewall of the mound.

f. No soil under or up to 50 feet down gradient of the mound may be removed or disturbed except as specified herein.

g. Construction equipment which would cause undesirable compaction of the soil shall be kept off the base area. Construction or plowing shall not be initiated when the soil moisture content is high. If a sample of soil from approximately 9 inches below the surface can be easily rolled into a 1/8- to 1/4-inch-diameter wire 1 1/2 inches long or more, the soil moisture content is too high for construction purposes.

h. Aboveground vegetation shall be closely cut and removed from the ground surface throughout the area to be utilized for the placement of the fill material.

i. The area shall be plowed to a depth of 7 to 8 inches, parallel to the land contour, with the plow throwing the soil up slope to provide a proper interface between the fill and the natural soil. Tree stumps should be cut flush with the surface of the ground, and roots should not be pulled.

j. The base absorption area of the mound is to be calculated based on the results of the percolation rate test or soil analysis as indicated in Table IIIa or IIIb and the flow rate.

k. The area of the fill material shall be sufficient to extend 3 feet beyond the edge of the gravel area before the sides are shaped to at least a 4:1 slope (preferably 5:1).

l. Distribution system.

(1) The distribution pipe shall be rigid plastic pipe, Schedule 40 or 80, with a 1-inch nominal diameter or equivalent design that ensures proper distribution.

(2) The distribution pipe shall be provided with a single row of ¼-inch perforations in a straight line 30 inches on center along the length of the pipe or an equivalent design that ensures uniform distribution. All joints and connections shall be solvent-cemented.

(3) The distribution pipe shall be placed in the clean, washed gravel (or crushed limestone as described in paragraph 69.9(4)“a”), with holes downward. The gravel shall be a minimum of 9 inches in depth below the pipe and 3 inches in depth above the pipe.

(4) No perforations shall be permitted within 3 inches of the outer ends of any distribution pipe.

(5) The outer ends of all pressure distribution lines shall be turned up, with a long 90-degree elbow or two 45-degree elbows to allow for cleaning. The outer ends will have a screw-on cap and cover. The cover shall be accessible from the ground surface without excavation.

(6) The central pressure manifold should consist of 1½- or 2-inch solid plastic pipe using a tee for connecting the distribution lines or an equivalent design that ensures uniform distribution.

m. Construction should be initiated immediately after preparation of the soil interface by placing all of the sand fill material needed for the mound (to the top of the trench) to a minimum depth of 21 inches above the plowed surface. This depth will permit excavation of the trenches to accommodate the 9 inches of washed gravel or crushed stone necessary for the distribution piping.

n. The absorption trench or trenches shall be hand-excavated to a depth of 9 inches. The bottoms of the trenches shall be level.

o. Nine inches of gravel shall be placed in the trench and leveled. After the distribution pipe is placed, the pipe shall be covered with 3 inches of gravel.

p. The top of the gravel shall be covered with synthetic drainage fabric. Unbacked, rolled, 3½-inch-thick fiberglass insulation, untreated building paper, or other suitable material may be used with approval of the administrative authority. Plastic or treated building paper shall not be used.

q. After installation of the distribution system, the distribution system shall be pressure-tested before it is covered with gravel. The entire mound is to be covered with topsoil native to the site or of similar characteristics to support vegetation found in the area. The entire mound shall be crowned by providing 12 inches of topsoil on the side slopes, with a minimum of 18 inches of topsoil over the center of the mound. The entire mound shall be seeded, sodded or otherwise provided with a grass cover to ensure stability of the installation.

r. The area surrounding the mound shall be graded to provide for diversion of surface runoff water.

69.10(4) Dosing.

a. Pump dosing shall be required for mound systems.

b. The dosing volume shall be three to ten times the distribution piping network volume, but not more than 25 percent of the design flow shall be applied to the soil in one dose.

c. The dosing pump shall be capable of maintaining a squirt height of 3 feet above the pipe at the outer ends of the distribution lines. All lines shall have an equal squirt height above the pipe to maintain equal distribution.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.11(455B) At-grade systems.**69.11(1) General requirements.**

a. At-grade systems shall be permitted only after a thorough site evaluation has been made and landscaping, dwelling placement, effect on surface drainage, and general topography have been considered.

b. At-grade systems shall not be utilized on sites subject to flooding with a ten-year or greater frequency.

c. At-grade systems shall not be utilized on soils where the high groundwater level, impermeable bedrock or soil strata having a percolation rate exceeding 60 minutes per inch occur within 36 inches of natural grade.

d. At-grade systems shall be constructed only upon undisturbed naturally occurring soils or where a soil analysis has determined the site is suitable.

e. At-grade systems shall be located in accordance with the distances specified in Table I as measured from the outer edge of the gravel in the system.

f. No buildings, driveways or other surface or subsurface obstructions shall be permitted within 25 feet on the down-gradient side of the at-grade system when the at-grade system is constructed on a slope greater than 5 percent. No future construction shall be permitted in this effluent disposal area as long as the at-grade system is in use.

g. Specifications given in these rules for at-grade systems are minimal and may not be sufficient for all applications. Technical specifications are changing with experience and research. Other design information beyond the scope of these rules may be necessary to properly design an at-grade system.

69.11(2) Construction details.

a. There shall be a minimum of 3 feet of undisturbed naturally occurring soils between the bottom of the gravel in the at-grade system and the highest elevation of the limiting conditions defined in paragraph 69.11(1) "c."

b. An at-grade system may be installed up to 12 inches deep.

c. Gravel shall meet the requirements specified in paragraph 69.9(4) "a." EPS aggregate or chambers are acceptable alternatives to gravel.

d. At-grade systems shall utilize an absorption bed distribution piping design. The bed shall be installed with the long dimension parallel to the land contour. Systems on steep slopes with slowly permeable soils should be narrow to reduce the possibility of toe seepage.

e. No soils under or within 15 feet of any at-grade system may be disturbed. On sloping sites, no soils shall be disturbed within 10 feet uphill of the system and within 15 feet downhill of the system plus an additional 5 feet for every 5 percent slope downhill.

f. Construction equipment which would cause undesirable compaction of the soil shall be kept off the base area. Construction or plowing shall not be initiated when the soil moisture content is high. If a sample of soil from approximately 9 inches below the surface can be easily rolled into a 1/8-inch diameter wire 1 1/2 inches long, the soil moisture content is too high for construction purposes.

g. Aboveground vegetation shall be closely cut and removed from the ground surface throughout the area to be utilized for the placement of the fill material.

h. The area shall be plowed to a minimum depth of 7 to 9 inches, parallel to the land contour, with the plow throwing the soil up slope to provide a proper interface between the fill and the natural soil. Chisel teeth on a backhoe bucket shall be at least as long as the depth of plowing. Tree stumps should be cut flush with the surface of the ground, and roots should not be pulled. All work shall be done from the uphill side of the at-grade system.

i. The gravel bed absorption area of the at-grade system is to be calculated based on the results of the percolation rate test or soil analysis as indicated in Table IIIa or IIIb and the flow rate.

j. One foot of loamy cover material shall be installed over the rock bed. Cover shall extend at least 5 feet from the ends of the rock bed and be sloped to divert surface water. Side slopes shall not be steeper than 4:1. The upper 6 inches of the loamy soil cover must be topsoil borrow. Topsoil borrow must be of a quality that provides a good vegetative cover on the at-grade system.

k. Distribution system.

- (1) The distribution pipe shall be rigid plastic pipe, Schedule 40 or 80 with a 1-inch nominal diameter or equivalent design that ensures proper distribution.
- (2) The distribution pipe shall be provided with a single row of ¼-inch perforations in a straight line 30 inches on center along the length of the pipe or an equivalent design that ensures uniform distribution. All joints and connections shall be solvent-cemented.
- (3) The distribution pipe shall be placed in the clean, washed gravel (or crushed limestone as described in paragraph 69.9(4) "a"), with holes downward. The gravel shall be a minimum of 10 inches in depth below the pipe and 2 inches in depth above the pipe.
- (4) Distribution pipe shall be installed in the center of the gravel bed on slopes less than 1 percent and on the upslope edge at the gravel bed absorption width on slopes 1 percent or greater.
- (5) No perforations shall be permitted within 3 inches of the outer ends of any distribution pipe.
- (6) The outer ends of all pressure distribution lines shall be turned up, with a long 90-degree elbow or two 45-degree elbows to allow for cleaning. The outer ends will have a screw-on cap and cover. The cover shall be accessible from the ground surface without excavation.
- (7) The central pressure manifold should consist of 1½- or 2-inch solid plastic pipe using a tee for connecting the distribution lines or an equivalent design that ensures uniform distribution.
- (8) The top of the gravel shall be covered with synthetic drainage fabric. Unbacked, rolled, 3½-inch-thick fiberglass insulation, untreated building paper, or other suitable material may be used with approval of the administrative authority. Plastic or treated building paper shall not be used.
- (9) After installation of the distribution system, the distribution system shall be pressure-tested before it is covered with gravel. The entire at-grade system is to be covered with topsoil native to the site or of similar characteristics to support vegetation found in the area. The entire at-grade system shall be crowned by providing 12 inches of topsoil on the side slopes, with a minimum of 18 inches of topsoil over the center of the at-grade system. The entire at-grade system shall be seeded, sodded or otherwise provided with a grass cover to ensure stability of the installation.
- (10) The area surrounding the at-grade system shall be graded to provide for diversion of surface runoff water.

69.11(3) Dosing.

- a. Pump dosing shall be required for at-grade systems.
- b. The dosing volume shall be three to ten times the distribution piping network volume, but not more than 25 percent of the design flow shall be applied to the soil in one dose.
- c. The dosing pump shall be capable of maintaining a squirt height of 3 feet above the pipe at the outer ends of the distribution lines. All lines shall have an equal squirt height above the pipe to maintain equal distribution.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.12(455B) Drip irrigation.

69.12(1) General design.

- a. *Pretreatment required.* Drip irrigation systems must be preceded by a secondary treatment system discharging a treated, filtered effluent with BOD and TSS values less than 30 mg/L.
- b. *Separation from groundwater.* Drip irrigation systems shall have a minimum vertical separation distance to high groundwater level or bedrock of 20 inches.
- c. *Maximum hillside slope.* Drip irrigation systems shall not be installed on slopes of more than 25 percent.
- d. *Additional specifications.* Specifications given in these rules for drip irrigation are minimal and may not be sufficient for all applications. Technical specifications are changing with experience and research. Other design information beyond the scope of these rules may be necessary to properly design a drip irrigation system.

69.12(2) Emitter layout.

- a. *Discharge rate.* Systems shall be designed so that emitters discharge approximately 1 gpm at 12 psi or other rates suggested by the manufacturer and approved by the administrative authority.

b. Grid size. Drip lines shall be run in parallel lines 2 feet apart. Emitters shall be placed in the drip lines at 2-foot intervals, with emitters offset 1 foot between adjacent lines. Each emitter shall cover 4 square feet of absorption area.

c. Field size. The field shall be sized according to the application rate given in Table IV.

d. Depth of drip lines. Drip lines shall be laid on the contour, 6 to 12 inches deep, with a maximum line length of 100 feet. Lines may be of unequal length.

e. Interconnection.

(1) All drip lines shall be connected to supply and return headers such that the entire system will automatically drain back to the dosing tank or pump pit upon completion of the pumping cycle. Vacuum breakers shall be positioned at the high point of the supply and return headers.

(2) The dosing tank shall have a high water audio/visual alarm.

Table IV
Length of Drip Line Required per Bedroom

Percolation Rate min./in.	Design Hyd. Loading gpd/sq. ft.	Length of Drip Line feet/bedroom
1 – 5	2.0	40
6 – 15	1.3	60
16 – 30	0.9	90
31 – 45	0.6	150
46 – 60	0.4	200
61 – 90	0.2	400
91 – 120	0.1	800

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.13(455B) Packed bed media filters.

69.13(1) Intermittent sand filters. The general requirements for intermittent sand filters are as follows:

a. Use. Intermittent sand filters may be used when the administrative authority determines the site is unacceptable for a soil absorption system.

b. Location. Intermittent sand filters shall be located in accordance with the distances specified in Table I.

c. Sampling port. The discharge point of the filter shall be accessible for effluent sampling, or a sampling port shall be installed in the discharge line.

d. Effluent sampling. All intermittent sand filters having an open discharge shall be sampled in accordance with the requirements of NPDES General Permit No. 4 if applicable.

e. Prohibited construction. There shall be no construction, such as buildings or concrete driveways, covering any part of an intermittent sand filter.

69.13(2) Construction.

a. Number. Rescinded IAB 7/11/12, effective 8/15/12.

b. Pipelines. Each bed shall contain a horizontal set of collector lines. The collector lines shall be equivalent to SDR 35 PVC pipe, 10-inch-diameter gravelless drainpipe, EPS aggregate or other suitable materials.

(1) One collector line shall be provided for each 6 feet of width or fraction thereof. A minimum of two collector lines shall be provided.

(2) The collector lines shall be laid to a grade of 1 inch in 10 feet (or 0.5 to 1.0 percent).

(3) Each collector line shall be vented or connected to a common vent. Vents shall extend at least 12 inches above the ground surface with the outlet screened or provided with a perforated cap.

(4) Gravelless drainfield pipe with fiber wrap may be used for the collector lines. If fiber wrap is used, no gravel or pea gravel is required to cover the collector lines and the pipe shall be bedded in filter sand.

(5) If 4-inch plastic pipe with perforations is used for the collector lines, the lines shall be covered as follows:

1. Gravel $\frac{3}{4}$ inch to $2\frac{1}{2}$ inches in size shall be placed around and over the lower collector lines until there is a minimum of 4 inches of gravel over the pipes.

2. The gravel shall be overlaid with a minimum of 3 inches of washed pea gravel $\frac{1}{8}$ -inch to $\frac{3}{8}$ -inch size interfacing with the filter media. A layer of fabric filter may be used in place of the pea gravel. Fabric filters must be 30 by 50 mesh with a percolation rate of at least 5 gal/sq. ft.

(6) A minimum of 24 inches of coarse washed sand shall be placed over the pea gravel or above the gravelless drainfield pipe. The sand shall meet the Iowa DOT standards for concrete sand: 100 percent of the sand shall pass a 9.5 mm screen, 90 to 100 percent shall pass a 4.75 mm screen, 70 to 100 percent shall pass a 2.36 mm screen, 10 to 60 percent shall pass a 600 Tm screen, and 0 to 1.5 percent shall pass a 75 Tm screen.

(7) The discharge pipe that extends from the collection system shall be SDR 35 PVC pipe at a minimum.

69.13(3) Subsurface sand filters.

a. Distribution system and cover.

(1) Gravel base. Six inches of gravel $\frac{3}{4}$ inch to $2\frac{1}{2}$ inches in size shall be placed upon the sand in the bed.

(2) Distribution lines. Distribution lines shall be level and shall be horizontally spaced a maximum of 3 feet apart, center to center. Distribution lines shall be rigid perforated PVC pipe.

(3) Venting. Venting shall be placed on the downstream end of the distribution lines, with each distribution line being vented or connected to a common vent. Vents shall extend at least 12 inches above the ground surface with the outlet screened or provided with a perforated cap.

(4) Gravel cover. Enough gravel shall be carefully placed to cover the distributors.

(5) Separation layer. A layer of material such as unbacked, rolled, $\frac{3}{2}$ -inch-thick fiberglass insulation, untreated building paper of 40- to 60-pound weight or synthetic drainage fabric shall be placed upon the top of the upper layer of gravel.

(6) Soil cover. A minimum of 12 inches of soil backfill shall be provided over the beds.

(7) Distribution boxes. A distribution box shall be provided for each filter bed where gravity distribution is used. The distribution boxes shall be placed upon undisturbed earth outside the filter bed. Separate watertight lines shall be provided leading from the distribution boxes to each of the distributor lines in the beds.

(8) As an alternative to gravel and rigid PVC pipe, EPS aggregate may be used for the distribution system. The EPS aggregate shall cover the entire surface of the sand filter, and a 3-foot separation between distribution pipes shall be maintained.

(9) Pressure distribution. Pressure dosing is recommended to improve effluent distribution across the surface of the filter. Pressure distribution systems may use conventional rock and PVC pipe, chambers with small-diameter pipe, or EPS aggregate with small-diameter pipe.

b. Sizing of subsurface sand filters.

(1) Gravity flow. For residential systems, subsurface sand filters shall be sized at a rate of 240 square feet of surface area per bedroom.

(2) Siphon-dosed. For residential systems, subsurface sand filters dosed by a dosing siphon shall be sized at a rate of 180 square feet of surface area per bedroom.

(3) Pressure-dosed. For residential systems, subsurface sand filters dosed by a pump shall be sized at a rate of 150 square feet of surface area per bedroom.

(4) Nonhousehold. Effluent application rates for commercial systems treating domestic waste shall not exceed the following:

1. 1.0 gallon/square feet/day for intermittent sand filters.

2. The total surface area for any subsurface sand filter system shall not be less than 200 square feet.

69.13(4) Free access sand filters.

a. Pretreatment required. These systems must be preceded by a secondary treatment system discharging a treated effluent with BOD and TSS values less than 30 mg/L.

b. Description. Media characteristics and underdrain systems for free access filters are similar to those for subsurface filters. Dosing of the filter should provide uniform distribution across the entire surface of the bed. Dosing frequency is usually greater than four times per day. For coarser media (greater than 0.5 mm), a dosing frequency greater than six times per day is desirable. Higher acceptable loadings on these filters as compared to subsurface filters relate primarily to the accessibility of the filter surface for maintenance. Gravel is not used on top of the sand media, and the distribution pipes are exposed above the surface.

c. Distribution. Distribution to the filter may be by perforated pipe laid on the surface, by pipelines discharging to splash plates located at the center or corners of the filter, or by spray distributors. Care must be taken to ensure that lines discharging directly to the filter surface do not erode the sand surface. The use of curbs around the splash plates or large stones placed around the periphery of the plates will reduce the scour. A layer of washed pea gravel placed over the filter media may also be employed to avoid surface erosion. This practice will create maintenance difficulties, however, when it is time to rake or remove a portion of the media surface.

d. Covers. Free access filters shall be covered to protect against severe weather conditions and to avoid encroachment of weeds or animals. The cover also serves to reduce odors. Covers may be constructed of treated wooden planks, galvanized metal, or other suitable material. Screens or hardware cloth mounted on wooden frames may also serve to protect filter surfaces. Where weather conditions dictate, covers should be insulated. A space of 12 to 24 inches should be allowed between the insulated cover and sand surface. Free access filters may not be buried by soil or sod.

e. Loading. The hydraulic loading for free access sand filters shall be 5.0 gpd/sq. ft.

69.13(5) Dosing. Dosing for sand filters is strongly advised. Without dosing, the entire area of the sand filter is never effectively used. Dosing not only improves treatment effectiveness but also decreases the chance of premature failure.

a. Pumps. A pump shall be installed when adequate elevation is not available for the system to operate by gravity.

(1) The pump shall be of corrosion-resistant material.

(2) The pump shall be installed in a watertight pit.

(3) The dosing system shall be designed to flood the entire filter during the dosing cycle. A dosing frequency of greater than two times per day is recommended.

(4) A high water alarm shall be installed.

b. Dosing siphons. When a dosing siphon is used where elevations permit, such siphon shall be installed as follows:

(1) Dosing siphons shall be installed between the septic tank and the sand filter bed.

(2) Dosing siphons shall be installed with strict adherence to the manufacturer's instructions.

c. Dosing tanks. The dosing tank shall be of such size that the siphon will distribute effluent over the entire filter during the dosing cycle. Smaller, more frequent doses are recommended.

d. Effluent sampling. A sampling port shall be available at the discharge point of the filter or shall be installed in the discharge line. All free access sand filters having an open discharge shall be sampled in accordance with the requirements of NPDES General Permit No. 4 if applicable.

69.13(6) Peat moss biofilter systems. General requirements for individual peat moss biofilter systems are as follows:

a. Use. Peat moss biofilter systems may be used when the administrative authority determines the site is unacceptable for a soil absorption system or an intermittent sand filter.

b. Certification. All peat moss biofilter systems shall be certified by an ANSI-accredited third-party certifier to meet National Sanitation Foundation Standard 40, Class I, including appendices (March 2008), or equivalent testing as determined by the department.

c. Installation and operation. All peat moss biofilter systems shall be preceded by a septic tank and installed, operated and maintained in accordance with the manufacturer's instructions and the requirements of the administrative authority. The septic tank shall be sized as specified in paragraph 69.8(2) "a" or larger if recommended by the manufacturer. Sizing of the system should be based on the manufacturer's specifications.

d. Maintenance contract. Prior to installation, a maintenance contract for the proper monitoring and servicing of the entire treatment system shall be established between the owner and a certified technician. A maintenance contract is required for the life of the system. All monitoring and servicing shall be performed by a manufacturer's certified technician. Manufacturers are responsible for ensuring that an adequate number of certified technicians are available to service all peat moss biofilters at the specified intervals. The certified technician shall perform the required maintenance and reporting to the owner and to the administrative authority. The certified technician shall also report any discontinuance of maintenance of the peat moss biofilter system to the administrative authority. Peat moss biofilter systems shall be inspected at least once annually by the certified technician. A copy of the maintenance contract shall be on file in the office of the administrative authority.

e. Effluent sampling. The discharge point of the filter shall be accessible for effluent sampling, or a sampling port shall be installed in the discharge line. All peat moss biofilter systems that have an open discharge shall be sampled in accordance with the requirements of NPDES General Permit No. 4 if applicable.

69.13(7) Recirculating textile filter systems. General requirements for recirculating textile filter systems are as follows:

a. Use. Recirculating textile filter systems may be used when the administrative authority determines the site is unacceptable for a soil absorption system or an intermittent sand filter.

b. Certification. All recirculating textile filter systems shall be certified by an ANSI-accredited third-party certifier to meet National Sanitation Foundation Standard 40, Class I, including appendices (March 2008), or equivalent testing as determined by the department.

c. Design. Recirculating textile filter systems shall be designed to prevent the passage of untreated waste during an equipment malfunction or power outage.

d. Installation and operation. Recirculating textile filter systems shall be preceded by a septic tank and installed, operated and maintained in accordance with the manufacturer's instructions and the requirements of the administrative authority. The septic tank shall be sized as specified in paragraph 69.8(2) "a" or larger if recommended by the manufacturer. Sizing of the system should be based on the manufacturer's specifications.

e. Maintenance contract. Prior to installation, a maintenance contract for the proper monitoring and servicing of the entire treatment system shall be established between the owner and a certified technician. A maintenance contract is required for the life of the system. All monitoring and servicing shall be performed by a manufacturer's certified technician. Manufacturers are responsible for ensuring that an adequate number of certified technicians are available to service all recirculating textile filters at the specified intervals. The certified technician shall perform the required maintenance and reporting to the owner and to the administrative authority. The certified technician shall also report any discontinuance of maintenance of the system to the administrative authority. Recirculating textile filter systems shall be inspected at least once annually by the certified technician. A copy of the maintenance contract shall be on file in the office of the administrative authority.

f. Effluent sampling. The discharge point of the filter shall be accessible for effluent sampling, or a sampling port shall be installed in the discharge line. All recirculating textile filter systems that have an open discharge shall be sampled in accordance with the requirements of NPDES General Permit No. 4 if applicable.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.14(455B) Aerobic treatment units. General requirements for aerobic treatment units are as follows:

69.14(1) Use. Aerobic treatment units may be used only when the administrative authority determines that the site is unacceptable for a soil absorption system or an intermittent sand filter. Because of the higher maintenance requirements of aerobic treatment units, preference should be given to packed bed media filters, where conditions allow.

69.14(2) Certification. All aerobic treatment units shall be certified by an ANSI-accredited third-party certifier to meet National Sanitation Foundation Standard 40, Class I, including appendices (March 2008), or equivalent testing as determined by the department.

69.14(3) Installation and operation. All aerobic treatment units shall be installed, operated and maintained in accordance with the manufacturer's instructions and the requirements of the administrative authority. The aerobic treatment units shall have a minimum treatment capacity of 150 gallons per bedroom per day or 500 gallons, whichever is greater.

69.14(4) Pre-tank required. All aerobic treatment units shall be preceded by a septic or trash tank with a minimum capacity of 500 gallons. The trash tank may be a single-compartment tank. A trash tank built in as part of the aerobic treatment unit's design satisfies this requirement.

69.14(5) Effluent treatment. The effluent from aerobic treatment units shall receive additional treatment through the use of intermittent sand filters or soil absorption systems of a magnitude prescribed in subrule 69.9(2) for pretreated effluent.

69.14(6) Maintenance contract. Prior to installation, a maintenance contract for the proper monitoring and servicing of the entire treatment system shall be established between the owner and a certified technician. A maintenance contract is required for the life of the system. All monitoring and servicing shall be performed by a manufacturer's certified technician. Manufacturers are responsible for ensuring that an adequate number of certified technicians are available to service all aerobic treatment units at the specified intervals. Aerobic treatment units shall be inspected for proper operation at least twice a year at six-month intervals by the certified technician.

69.14(7) Effluent sampling. The discharge point of the aerobic treatment unit system shall be accessible for effluent sampling, or a sampling port shall be installed in the discharge line. All aerobic treatment unit systems that have an open discharge shall be sampled in accordance with the requirements of NPDES General Permit No. 4 if applicable.

[ARC 7569B, IAB 2/11/09, effective 3/18/09; ARC 0208C, IAB 7/11/12, effective 8/15/12]

567—69.15(455B) Constructed wetlands.

69.15(1) General site design.

a. Application. Constructed wetlands shall only be used where soil percolation rates at the site exceed 120 minutes per inch. Because of the higher maintenance requirements of constructed wetland systems, preference should be given to packed bed media filters, where conditions allow.

b. Effluent treatment. The effluent from a constructed wetland shall receive additional treatment through the use of intermittent sand filters of a magnitude prescribed in subrule 69.9(2) for pretreated effluent.

c. Effluent sampling. All constructed wetland systems having an open discharge shall be sampled in accordance with the requirements of NPDES General Permit No. 4 if applicable.

d. Additional specifications. Specifications given in this rule for constructed wetlands are minimal and may not be sufficient for all applications. Technical specifications are changing with experience and research. Other design information beyond the scope of this rule may be necessary to properly design a constructed wetland system.

69.15(2) Wetland design.

a. Depth. The wetland shall be of a subsurface flow construction with a rock depth of 18 inches and a liquid depth of 12 inches.

b. Materials. Substrate shall be washed river gravel with a diameter of ¾ inch to 2½ inches. If crushed quarried stone is used, it must meet the criteria listed in paragraph 69.9(4) "a."

c. Sizing and configuration. Detention time shall be a minimum of seven days.

(1) Dimensions. Detention time may be accomplished with trenches 16 to 18 inches deep (12 inches of liquid), 3 feet wide, with 100 feet of length per bedroom. Detention time may also be done

with beds 16 to 18 inches deep, with at least 300 square feet of surface area per bedroom. The bottom of each trench or bed must be level within $\pm\frac{1}{2}$ inch.

(2) Configuration. Multiple trenches or beds in series should be used. Beds or trenches in series may be stepped down in elevation to fit a hillside application. If the system is on one elevation, it should still be divided into units by earthen berms at about 50 and 75 percent of the total length.

(3) Unit connections. Each subunit shall be connected to the next subunit with an overflow pipe (rigid sewer pipe) that maintains the water level in the first section. Protection from freezing may be necessary.

d. Liner. Wetlands shall be lined with a synthetic PVC or PE plastic liner 20 to 30 mils thick.

e. Inlet pipe. Effluent shall enter the wetland by a 4-inch pipe sealed into the liner. With beds, a header pipe shall be installed along the inlet side to distribute the waste.

f. Protective berms. Wetland system sites shall be bermed to prevent surface water from entering the trenches or beds.

69.15(3) Vegetation.

a. Setting plants. Vegetation shall be established on the wetlands at the time of construction. Twelve inches of rock shall be placed in each unit, the plants set, and then the final 4 to 6 inches of rock placed.

b. Plant species. Only indigenous plant species, preferably collected within a 100-mile radius of the site, shall be set. Multiple species in each system are recommended. Preferred species include, but are not limited to:

- (1) *Typha latifolia* – common cattail.
- (2) *Typha angustifolia* – narrow leaf cattail.
- (3) *Scirpus* spp. – bullrush.
- (4) *Phragmites communis* – reed.

c. Plant establishment. Transplantation is the recommended method of vegetation establishment. For transplanting, the propagule should be transplanted, at a minimum, on a 2-foot grid. The transplants should be fertilized, preferably with a controlled-release fertilizer such as Osmocote 18-5-11 for fall and winter planting, 18-6-12 for spring planting, and 19-6-12 for summer planting. Trenches or beds should be filled with fresh water immediately.

d. Plant management. In the late fall, the vegetation shall be mowed and the detritus left on the wetland surface as a temperature mulch. In the early spring, the mulch shall be removed and disposed of to allow for adequate bed aeration.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.16(455B) Waste stabilization ponds.

69.16(1) General requirements. Waste stabilization ponds shall only be used for nonresidential applications and shall be designed by an Iowa-licensed engineer. Waste stabilization ponds may be used if designed and constructed in accordance with the following criteria and provided the effluent is discharged in accordance with the requirements of the NPDES general permit listed in rule 567—69.4(455B). A septic tank sized according to rule 567—69.8(455B) shall precede a waste stabilization pond.

69.16(2) Location. Waste stabilization ponds must meet the following separation distances:

a. 1,000 feet from the nearest inhabitable residence, commercial building, or other inhabitable structure. If the inhabitable or commercial building is the property of the owner of the proposed treatment facility or there is written agreement with the owner of the building, this separation criterion shall not apply. Any such written agreement shall be filed with the county recorder and recorded for abstract of title purposes, and a copy submitted to the department.

b. 1,000 feet from public shallow wells.

c. 400 feet from public deep wells.

d. 400 feet from private wells.

e. 400 feet from lakes and public impoundments.

f. 25 feet from property lines and rights-of-way.

69.16(3) Size.

- a. *Dimensions.* Ponds shall have a length not exceeding three times the width.
- b. *Capacity.* When domestic sewage from a septic tank is to be discharged to a waste stabilization pond, the capacity of the pond shall be equivalent to 180 times the average daily design flow.
- c. *Depth.* The wastewater depth for a waste stabilization pond shall be 3 feet to 5 feet and shall be uniform.
- d. *Freeboard.* A minimum freeboard of 2 feet shall be maintained at all times.

69.16(4) Embankments.

- a. *Seal.* Embankments shall be constructed of impermeable materials and shall be compacted. The bottom of the waste stabilization pond shall be cleared and leveled to the required elevation and shall be lined with an impermeable natural or man-made material. Seepage loss through the sides and bottom shall be less than 1/16 inch per day.
- b. *Slopes.* The ratio of inside embankment slopes shall be 3 horizontal to 1 vertical. The outside embankment slope ratio shall be at least 3:1.
- c. *Berm top.* Berm tops shall be at least 4 feet wide.
- d. *Cover.* Embankments shall be seeded from the outside toe to the inside high water line. From the high water line down the embankment diagonally, about 5 feet shall be ripped for erosion and vegetation control.

69.16(5) Inlet and outlet structures.

- a. *Inlet.* The inlet shall be placed no higher than 12 inches above the bottom of the pond. It shall discharge near the middle of the pond at a point opposite the overflow structure and onto a concrete splash plate at least 2 feet square.
- b. *Outlet.* The outlet pipe shall withdraw water from a submerged depth of at least 1 foot. The intake for the outlet pipe shall be 3 to 5 feet from the embankment.
- c. *Separation.* The inlet and outlet should be separated to the maximum extent possible, ideally by a berm or baffle constructed in the lagoon to prevent short-circuiting.

69.16(6) Drainage. All surface water shall be diverted away from the waste stabilization pond.

69.16(7) Effluent sampling. All waste stabilization ponds having an open discharge shall be sampled in accordance with the requirements of NPDES General Permit No. 4 if applicable.

69.16(8) Maintenance.

- a. *Fencing.* All waste stabilization ponds are to be fenced adequately to prevent entrance of livestock and to discourage entrance by people into the area. Signs shall be posted warning of possible health and safety hazards.
- b. *Vegetation.* Vegetation on the top and sides of the berm shall be mowed and the length maintained. No trees shall be allowed to become established.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.17(455B) Requirements for impervious vault toilets. All impervious vault toilets shall comply with the following requirements:

69.17(1) Location. Impervious vault toilets shall be located in accordance with the distances given in Table I in rule 567—69.3(455B) for the closed portion of the treatment system.

69.17(2) Construction. The vault shall be constructed of reinforced, impervious concrete at least 4 inches thick. The superstructure including floor slab, seat, seat cover, riser and building shall comply with good design and construction practices to provide permanent, safe, sanitary facilities. The vault shall be provided with a cleanout opening fitted with a fly-tight cover.

69.17(3) Wastewater disposal. Wastewater from impervious vault toilets shall be disposed of at a public sewage treatment facility.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.18(455B) Requirements for portable toilets. All portable toilets shall be designed to receive and retain the wastes deposited in them and shall be located and maintained in a manner that will prevent

the creation of any nuisance condition. Wastewater from portable toilets shall be disposed of at a public sewage treatment facility.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.19(455B) Other methods of wastewater disposal. Other methods or types of private wastewater treatment and disposal systems shall be installed only after plans and specifications for each project have been approved by the administrative authority.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.20(455B) Disposal of septage from private sewage disposal systems.

69.20(1) The collection, storage, transportation and disposal of all septage shall be carried out in accordance with the requirements in 567—Chapter 68.

69.20(2) Commercial septic tank cleaners. Individual administrative authorities shall enforce the licensing program for commercial septic tank cleaners in accordance with the requirements of 567—Chapter 68.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.21(455B) Experimental private sewage disposal systems.

69.21(1) Design requirements. Experimental systems are to be designed and operated in accordance with approved standards and operating procedures established by individual administrative authorities.

a. Plans and specifications, meeting all applicable rule requirements, should be prepared and submitted to the administrative authorities by a licensed professional engineer. Included with the engineering submittal should be adequate supporting data relating to the effectiveness of the proposed system.

b. For systems designed to discharge treated effluent into waters of the state, a Notice of Intent to be covered under the requirements of NPDES General Permit No. 4 shall be obtained. The administrative authority is responsible for determining that the requirements of the permit, including the monitoring program, are met.

c. Administrative authorities should prepare for signature an enforceable agreement to be placed on record which would require that present and future system owners meet all applicable rule requirements. In the event of noncompliance, the administrative authority shall require that adequate steps be taken by the system owner to bring the system into compliance or that the system owner replace the system with a system prescribed in these rules.

69.21(2) Reserved.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

567—69.22(455B) Variances. Variances to these rules may be granted by the department of natural resources or the administrative authority provided sufficient information is submitted to substantiate the need for and propriety of such action. Applications for variances and justification shall be in writing and copies filed with the department.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

These rules are intended to implement Iowa Code chapter 455B, division III, part 1.

Appendix A
Estimates of Nonhousehold Domestic Sewage Flow Rates

Source of use for sewage unit	(units)	Gallons per day per unit
Dwelling Units		
Hotels or luxury motels	(Each guest)	60
	(Add per employee)	13
or	(Per square foot)	0.3
Discount motels	(Each guest)	40
	(Add per employee)	13
or	(Per square foot)	0.46
Rooming house	(Each resident)	50
	(Add per nonresident meal)	4.0
Commercial/Industrial		
Retail stores	(Per square foot of sales area)	0.15
or	(Each customer)	5
	(Plus each employee)	15
or	(Each toilet room)	630
Offices	(Each employee)	18
or	(Per square foot)	0.25
Medical offices	(Per square foot)	1.6
Industrial buildings	(Each employee)	20
	(Does not include process ware or cafeteria)	
Construction camp	(Each employee)	20
Visitor center	(Each visitor)	20
Laundromat	(Each machine)	690
or	(Each load)	50
or	(Per square foot)	2.9
Barber shops	(Per chair)	80
Beauty shops	(Per station)	300
Car washes	(Per inside square foot)	10
	(Does not include car wash water)	
Eating and Drinking Establishments		
Restaurant	(Per meal)	4.0
	(Does not include bar or lounge)	
or	(Each seat)	40
	(Plus add for each employee)	13
Dining hall	(Per meal)	4.0
Coffee shop	(Each customer)	2.5
	(Add per employee)	13
Cafeteria	(Each customer)	2.5
	(Add per employee)	13
Drive-in	(Per car stall)	145
Bar or lounge	(Each customer)	5.5
	(Add per employee)	16

Source of use for sewage unit	(units)	Gallons per day per unit
or	(Per seat)	40
Country clubs	(Per member) (No meals)	22
or	(Per member) (Meals and showers)	130
or	(Per member in residence)	100
Resorts		
Housekeeping cabin	(Per person)	50
Lodge	(Per person)	74
Parks/swimming pools	(Per guest)	13
Picnic parks with toilet only	(Per guest)	10
Movie theaters	(Per guest)	4.0
Drive-in theaters	(Per space)	5
Skating rink/dance hall	(Per customer)	10
Bowling lanes	(Per lane)	200
Transportation		
Airport, bus or rail depot	(Per passenger)	4
or	(Per square foot)	6.5
or	(Per public restroom)	630
Auto service station	(Each vehicle served)	13
	(Add per employee)	16
or	(Per inside square foot)	0.6
or	(Per public restroom)	630
Institutional		
Hospitals	(Each medical bed)	250
	(Add per employee)	16
Mental institution	(Each bed)	175
	(Add per employee)	16
Prison or jail	(Each inmate)	160
	(Add per employee)	16
Nursing home	(Each resident)	145
	(Add per employee)	16
Schools and Churches		
School	(Per student) (No gym, cafeteria or showers)	17
	(Per student) (Cafeteria only)	17
	(Per student) (Cafeteria, gym & showers)	30
Boarding school	(Per student)	115
Churches	(Per member)	2
	(Per member with kitchen)	5

Source of use for sewage unit	(units)	Gallons per day per unit
Recreational		
Campground/with hookups	(Per person)	40
or	(Per site with central bath)	100
	(Per site)	75
	(Add for dump station w/ hookup)	16
Day camp (no meals)	(Per person)	16
Weekly overnight camp	(Per member)	33

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

Appendix B Percolation Test Procedure

1. At least three test holes distributed evenly over the proposed lateral field are required.
2. Percolation test holes shall be 4 to 12 inches in diameter and to the same depth as the proposed absorption trenches (not to exceed 36 inches in depth).
3. Sides and bottoms of the test holes shall be scratched or roughened to provide a natural surface. All loose material shall be removed from each hole.
4. The bottoms of the test holes shall be covered with approximately 2 inches of rock to protect the bottom from scouring action when the water is added.
5. The hole shall be filled with at least 12 inches of clean water, and this depth shall be maintained for at least 4 hours and preferably overnight if clay soils are present. It is important that the soil be allowed to soak for a sufficiently long period of time to allow the soil to swell if accurate results are to be obtained. Failure to perform the presoak when required will invalidate the percolation test results.
6. In sandy soils with little or no clay, soaking is not necessary. If, after the hole has been filled twice with 12 inches of water, the water seeps completely away in less than 10 minutes, the test can proceed immediately.
7. Except for sandy soils, percolation rate measurements should be made at least 4 hours but no more than 24 hours after the soaking period began. Any soil that sloughed into the hole during the soaking period is removed, and the water level is adjusted to 6 inches above the gravel (or 8 inches above the bottom of the hole). At no time during the test is the water level allowed to rise more than 6 inches above the gravel.
8. Immediately after adjustment, the water level is measured from a fixed reference point to the nearest $\frac{1}{8}$ inch at 30-minute intervals. The test is continued until two successive water level drops do not vary by more than $\frac{1}{8}$ inch. At least three measurements are made.
9. After each measurement, the water level is readjusted to the 6-inch level. The last water level drop is used to calculate the percolation rate.
10. In sandy soils or soils in which the first 6 inches of water added after the soaking period seep away in less than 30 minutes, water level measurements are made at 10-minute intervals for a 1-hour period. The last water level drop is used to calculate the percolation rate.
11. The percolation rate is calculated for each test hole by dividing the time interval used between measurements by the magnitude of the last water level drop. This calculation results in a percolation rate in terms of minutes per inch. To determine the percolation rate for the area, the rates obtained from each hole are averaged. (If tests in the area vary by more than 20 minutes per inch, variations in soil type are indicated. Under these circumstances, percolation rates should not be averaged.) EXAMPLE: If the last measured drop in water level after 30 minutes is $\frac{5}{8}$ inch, the percolation rate = (30 minutes)/($\frac{5}{8}$ inch) = 48 minutes/inch.

[ARC 7569B, IAB 2/11/09, effective 3/18/09]

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CHAPTER 106
DEER HUNTING BY RESIDENTS
[Prior to 12/31/86, Conservation Commission[290] Ch 106]

571—106.1(481A) Licenses. When hunting deer, all hunters must have in their possession a valid deer hunting license and a valid resident hunting license and must have paid the habitat fee (if normally required to have a hunting license and to pay the habitat fee to hunt). No person while hunting deer shall carry or have in possession any license or transportation tag issued to another person. No one who is issued a deer hunting license and transportation tag shall allow another person to use or possess that license or transportation tag while that person is deer hunting or tagging a deer.

106.1(1) Type of license.

a. Any-deer licenses. Any-deer licenses shall be valid for taking deer of either sex in one season selected at the time the license is purchased. Paid any-deer licenses shall be valid statewide except where prohibited in deer population management zones established under 571—Chapter 105. Free any-deer licenses shall be valid only on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

b. Antlerless-deer-only licenses. Antlerless-deer-only licenses shall be valid for taking deer that have no forked antler. Paid antlerless-deer-only licenses shall be valid in one county or in one deer population management zone and in one season as selected at the time the license is purchased. Free and reduced-fee antlerless-deer-only licenses shall be valid on the farm unit of an eligible landowner or tenant in the season or seasons selected at the time the license is obtained.

106.1(2) Bow season licenses. Any-deer and antlerless-deer-only licenses, paid or free, shall be valid in both segments of the bow season.

106.1(3) Regular gun season licenses. Paid any-deer and antlerless-deer-only licenses shall be valid in either the first or the second regular gun season, as designated on the license. Free any-deer licenses and antlerless-deer-only licenses shall be valid in both the first and second regular gun seasons.

106.1(4) Muzzleloader season licenses. Any-deer and antlerless-deer-only licenses, paid or free, shall be valid in either the early or the late muzzleloader season, as designated on the license.

106.1(5) November antlerless-deer-only licenses. Rescinded IAB 7/11/12, effective 8/15/12.

106.1(6) January antlerless-deer-only licenses. Only antlerless-deer-only licenses, paid or free, will be issued for the January antlerless-deer-only season. Free antlerless-deer-only licenses shall be available only in the portion of the farm unit located in a county where paid antlerless-deer-only licenses are available during that season.

106.1(7) Free and reduced-fee deer licenses for landowners and tenants. A maximum of one free any-deer license, two free antlerless-deer-only licenses, and two reduced-fee antlerless-deer-only licenses may be issued to a qualifying landowner or eligible family member and a qualifying tenant or eligible family member. Eligibility for licenses is described in 571—106.12(481A). The free any-deer license shall be available for one of the following seasons: the youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, or first and second regular gun seasons. One free antlerless-deer-only license shall be available for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, or first and second regular gun seasons. The second free antlerless-deer-only license shall be valid only for the January antlerless-deer-only season and will be available only if a portion of the farm unit lies within a county where paid antlerless-deer-only licenses are available during that season. Each reduced-fee antlerless-deer-only license shall be valid for one of the following seasons: youth/disabled hunter season (if eligible), bow season, early muzzleloader season, late muzzleloader season, first and second regular gun seasons, or January antlerless-deer-only season. January antlerless-deer-only licenses will be available only if a portion of the farm unit is located in a county where paid antlerless-deer-only licenses are available in that season.

106.1(8) Antlerless-deer-only crossbow licenses for senior citizens. Persons 70 years old or older may obtain one paid antlerless-deer-only license valid statewide for taking antlerless deer with a crossbow. The license will be valid only during the bow season.

106.1(9) Nonambulatory deer hunting licenses. The commission shall issue licenses in conformance with 2009 Iowa Acts, Senate File 187. A person applying for this license must provide a completed form obtained from the department of natural resources. The application shall be certified by the applicant's attending physician with an original signature and declare that the applicant is nonambulatory using the criteria listed in 2009 Iowa Acts, Senate File 187. A medical statement from the applicant's attending physician that specifies criteria met shall be on 8½" × 11" letterhead stationery. The attending physician shall be a currently practicing doctor of medicine, doctor of osteopathy, physician assistant or nurse practitioner.

[ARC 7921B, IAB 7/1/09, effective 8/5/09; ARC 8255B, IAB 11/4/09, effective 12/9/09; ARC 8888B, IAB 6/30/10, effective 8/18/10; ARC 0189C, IAB 7/11/12, effective 8/15/12]

571—106.2(481A) Season dates. Deer may be taken only during the following seasons:

106.2(1) Bow season. Deer may be taken in accordance with the type of license issued from October 1 through the Friday before the first Saturday in December and from the Monday following the third Saturday in December through January 10 of the following year.

106.2(2) Regular gun seasons. Deer may be taken in accordance with the type, season and zone designated on the license from the first Saturday in December and continuing for five consecutive days (first regular gun season) or from the second Saturday in December and continuing for nine consecutive days (second regular gun season).

106.2(3) Muzzleloader seasons. Deer may be taken in accordance with the type, season and zone designated on the license from the Saturday closest to October 14 and continuing for nine consecutive days (early muzzleloader season) or from the Monday following the third Saturday in December through January 10 of the following year (late muzzleloader season).

106.2(4) November antlerless-deer-only season. Rescinded IAB 7/11/12, effective 8/15/12.

106.2(5) January antlerless-deer-only season. Antlerless deer may be taken from January 11 through the second following Sunday.

[ARC 0189C, IAB 7/11/12, effective 8/15/12]

571—106.3(481A) Shooting hours. Legal shooting hours shall be from one-half hour before sunrise to one-half hour after sunset in all seasons.

571—106.4(481A) Limits.

106.4(1) Bow season. The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(2) Muzzleloader seasons. The daily bag limit is one deer per license. The possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.4(3) Regular gun seasons. The bag limit is one deer for each hunter in the party who has a valid deer transportation tag. The possession limit is one deer per license. "Possession" shall mean that the deer is in the possession of the person whose license number matches the number of the transportation tag on the carcass of the deer.

106.4(4) November antlerless-deer-only season. Rescinded IAB 7/11/12, effective 8/15/12.

106.4(5) January antlerless-deer-only season. The daily bag and possession limit and the tagging requirements are the same as for the regular gun seasons.

106.4(6) Maximum annual possession limit. The maximum annual possession limit for a resident deer hunter is one deer for each legal license and transportation tag obtained.

[ARC 0189C, IAB 7/11/12, effective 8/15/12]

571—106.5(481A) Areas closed to hunting. There shall be no open seasons for hunting deer on the county roads immediately adjacent to or through Union Slough National Wildlife Refuge, Kossuth County, where posted accordingly. There shall be no open seasons for hunting deer on all portions of rights-of-way on Interstate Highways 29, 35, 80 and 380.

571—106.6(481A) Paid deer license quotas and restrictions. Paid deer licenses, including antlerless-deer-only licenses, will be restricted in the type and number that may be purchased.

106.6(1) Paid any-deer licenses. Residents may purchase no more than two paid any-deer licenses, one for the bow season and one for one of the following seasons: early muzzleloader season, late muzzleloader season, first regular gun season, or second regular gun season. No more than 7,500 paid statewide any-deer licenses will be sold for the early muzzleloader season. Fifty additional paid early muzzleloader season licenses will be sold through and will be valid only for the Iowa Army Ammunition Plant. There will be no quota on the number of paid any-deer licenses issued in the bow season, late muzzleloader season, first regular gun season, or second regular gun season.

106.6(2) Paid antlerless-deer-only licenses. Paid antlerless-deer-only licenses have quotas for each county and will be sold for each county until quotas are reached.

a. Paid antlerless-deer-only licenses may be purchased for any season in counties where licenses are available, except as outlined in 106.6(2)“*b.*” A license must be used in the season, county or deer population management area selected at the time the license is purchased.

b. No one may obtain paid licenses for both the first regular gun season and second regular gun season regardless of whether the licenses are valid for any deer or antlerless deer only. Paid antlerless-deer-only licenses for the early muzzleloader season may only be purchased by hunters who have already purchased one of the 7,500 paid statewide any-deer licenses. Hunters who purchase one of the 7,500 paid statewide any-deer licenses for the early muzzleloader season may not obtain paid antlerless licenses for the first or second regular gun season.

c. Prior to September 15, a hunter may purchase one antlerless-deer-only license for any season for which the hunter is eligible. Beginning September 15, a hunter may purchase an unlimited number of antlerless-deer-only licenses for any season for which the hunter is eligible, as set forth in 106.6(2)“*b.*” until the county or population management area quotas are filled. Licenses purchased for deer population management areas will not count in the county quota.

106.6(3) November antlerless-deer-only season. Rescinded IAB 7/11/12, effective 8/15/12.

106.6(4) January antlerless-deer-only licenses. Antlerless-deer-only licenses for the January antlerless-deer-only season shall be available in the following counties: Adair, Adams, Appanoose, Cass, Clarke, Dallas, Davis, Decatur, Des Moines, Fremont, Guthrie, Harrison, Henry, Jasper, Jefferson, Keokuk, Lee, Louisa, Lucas, Madison, Mahaska, Marion, Mills, Monona, Monroe, Montgomery, Page, Polk, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, and Woodbury. Beginning December 15, an unlimited number of paid antlerless-deer-only licenses may be purchased for the January antlerless-deer-only season. These licenses may be obtained regardless of any other paid any-deer or paid antlerless-deer-only licenses that may have been obtained.

106.6(5) Free landowner/tenant licenses. A person obtaining a free landowner/tenant license may purchase any combination of paid bow and paid gun licenses available to persons who are not eligible for landowner/tenant licenses as described in 571—106.12(481A).

106.6(6) Antlerless-deer-only licenses. Paid antlerless-deer-only licenses will be available by county as follows:

<u>County</u>	<u>Quota</u>	<u>County</u>	<u>Quota</u>	<u>County</u>	<u>Quota</u>
Adair	2400	Floyd	0	Monona	2500
Adams	1950	Franklin	0	Monroe	3000
Allamakee	4500	Fremont	1500	Montgomery	1300
Appanoose	3300	Greene	150	Muscatine	1175
Audubon	100	Grundy	0	O’Brien	0
Benton	650	Guthrie	3300	Osceola	0
Black Hawk	0	Hamilton	100	Page	1800
Boone	650	Hancock	0	Palo Alto	0
Bremer	1000	Hardin	200	Plymouth	100
Buchanan	250	Harrison	2500	Pocahontas	0

<u>County</u>	<u>Quota</u>	<u>County</u>	<u>Quota</u>	<u>County</u>	<u>Quota</u>
Buena Vista	0	Henry	1025	Polk	1500
Butler	0	Howard	350	Pottawattamie	2100
Calhoun	0	Humboldt	0	Poweshiek	500
Carroll	100	Ida	0	Ringgold	2600
Cass	1300	Iowa	775	Sac	0
Cedar	1025	Jackson	1250	Scott	500
Cerro Gordo	0	Jasper	1700	Shelby	400
Cherokee	0	Jefferson	2150	Sioux	0
Chickasaw	450	Johnson	1400	Story	500
Clarke	2500	Jones	975	Tama	500
Clay	0	Keokuk	1900	Taylor	2650
Clayton	3200	Kossuth	0	Union	2100
Clinton	825	Lee	1400	Van Buren	5400
Crawford	300	Linn	1300	Wapello	2150
Dallas	2700	Louisa	850	Warren	4200
Davis	3600	Lucas	2800	Washington	2250
Decatur	2800	Lyon	0	Wayne	3000
Delaware	975	Madison	4000	Webster	100
Des Moines	900	Mahaska	1350	Winnebago	0
Dickinson	0	Marion	2250	Winneshiek	3500
Dubuque	1375	Marshall	500	Woodbury	2500
Emmet	0	Mills	1350	Worth	0
Fayette	1650	Mitchell	0	Wright	0

[ARC 7921B, IAB 7/1/09, effective 8/5/09; ARC 8888B, IAB 6/30/10, effective 8/18/10; ARC 0189C, IAB 7/11/12, effective 8/15/12]

571—106.7(481A) Method of take. Permitted weapons and devices vary according to the type of season.

106.7(1) Bow season. Only longbow, compound or recurve bows shooting broadhead arrows are permitted during the bow season. Arrows must be at least 18 inches long.

a. Crossbows may be used during the bow season in the following two situations:

(1) By persons with certain afflictions of the upper body as provided in 571—15.5(481A); and

(2) By persons over the age of 70 with an antlerless-deer-only license as provided in Iowa Code section 483A.8A.

b. No explosive or chemical devices may be attached to the arrow, broadhead or bolt (if used with a crossbow).

106.7(2) Regular gun seasons. Only 10-, 12-, 16- and 20-gauge shotguns shooting single slugs and muzzleloaders and handguns as described in 106.7(3) will be permitted for taking deer during the regular gun seasons.

106.7(3) Muzzleloader seasons. Only muzzleloading rifles and muzzleloading pistols will be permitted for taking deer during the early muzzleloader season. During the late muzzleloader season, deer may be taken with a muzzleloader, centerfire handgun, or bow as described in 106.7(1). Muzzleloading rifles are defined as flintlock or percussion cap lock muzzleloaded rifles and muskets of not less than .44 and not larger than .775 caliber, shooting single projectiles only. Centerfire handguns must be .357 caliber or larger shooting straight-walled cartridges propelling an expanding-type bullet (no full-metal jacket) and complying with all other requirements provided in Iowa Code section 481A.48. Legal handgun calibers are listed on the department of natural resources list of Acceptable Handgun Calibers for Hunting Deer in Iowa. Revolvers, pistols and black powder handguns must

have a 4-inch minimum barrel length. There can be no shoulder stock or long-barrel modifications to handguns. Muzzleloading handguns must be .44 caliber or larger, shooting single projectiles only.

106.7(4) *November antlerless-deer-only season.* Rescinded IAB 7/11/12, effective 8/15/12.

106.7(5) *January antlerless-deer-only season.* Bows, shotguns, muzzleloaders and handguns as described in this rule may be used during the January antlerless-deer-only season. Centerfire rifles .24 caliber or larger may be used in the southern two tiers of counties.

106.7(6) *Prohibited weapons and devices.* The use of dogs, domestic animals, bait, rifles other than muzzleloaded or as provided in 106.7(5), handguns except as provided in 106.7(3), crossbows except as provided in 106.7(1), automobiles, aircraft, or any mechanical conveyance or device, including electronic calls, is prohibited, except that paraplegics and single or double amputees of the legs may hunt from any stationary motor-driven land conveyance. "Bait" means grain, fruit, vegetables, nuts, hay, salt, mineral blocks, or any other natural food materials; commercial products containing natural food materials; or by-products of such materials transported to or placed in an area for the intent of attracting wildlife. Bait does not include food placed during normal agricultural activities. "Paraplegic" means an individual with paralysis of the lower half of the body with involvement of both legs, usually due to disease or injury to the spinal cord. It shall be unlawful for a person, while hunting deer, to carry or have in possession a rifle except as provided in 106.7(3) and 106.7(5). It shall be unlawful for a person hunting with a bow license to carry a handgun unless that person also has a valid deer hunting license and an unfilled transportation tag that permits a handgun to be used to take deer.

106.7(7) *Discharge of firearms from roadway.* No person shall discharge a rifle, including a muzzleloading rifle or musket, or a handgun from a highway while deer hunting. In addition, no person shall discharge a shotgun shooting slugs from a highway north of U.S. Highway 30. A "highway" means the way between property lines open to the public for vehicle traffic, including the road ditch, as defined in Iowa Code section 321.1(78).

106.7(8) *Hunting from blinds.* No person shall use a blind for hunting deer during the regular gun deer seasons as defined in 106.2(2), unless such blind exhibits a solid blaze orange marking which is a minimum of 144 square inches in size and is visible in all directions. Such blaze orange shall be affixed directly on or directly on top of the blind. For the purposes of this subrule, the term "blind" is defined as an enclosure used for concealment while hunting, constructed either wholly or partially from man-made materials, and used by a person who is hunting for the purpose of hiding from sight. A blind is not a naturally occurring landscape feature or an arrangement of natural or agricultural plant material that a hunter uses for concealment. In addition to the requirements in this subrule, hunters using blinds must also satisfy the requirements of wearing blaze orange as prescribed in Iowa Code section 481A.122.

[ARC 9717B, IAB 9/7/11, effective 10/12/11; ARC 0189C, IAB 7/11/12, effective 8/15/12]

571—106.8(481A) Procedures to obtain licenses. All resident deer hunting licenses must be obtained using the electronic licensing system for Iowa (ELSI). Licenses may be purchased from ELSI license agents, or online at www.iowadnr.com, or by calling the ELSI telephone ordering system.

106.8(1) *Licenses with quotas.* All paid deer hunting licenses for which a quota is established may be obtained from the ELSI system on a first-come, first-served basis beginning August 15 until the quota fills, or through the last day of the hunting period for which the license is valid.

106.8(2) *Licenses without quotas.* All deer hunting licenses that have no quota may be obtained from the ELSI system beginning August 15 through the last day of the hunting period for which a license is valid.

106.8(3) *Providing false information.*

a. Any person who provides false information about the person's identity or eligibility for any paid or free landowner/tenant deer license and tag and who attests that the information is correct by accepting and signing the license or tag shall have the person's hunting license revoked as a part of the sentencing for such criminal conviction, and the person shall not be issued a hunting license for one year pursuant to the authority of Iowa Code Supplement section 483A.24(2) "f" and rule 571—15.6(483A).

b. In addition to any legal penalties that may be imposed, the obtaining of a license in violation of this rule shall invalidate that deer license and transportation tag and any other deer hunting license and transportation tag obtained during the same year.

571—106.9(481A) Transportation tag. A transportation tag bearing the license number of the licensee, year of issuance, and date of kill properly shown shall be visibly attached to one leg of each antlerless deer or on the main beam between two points, if present, on one of the antlers of an antlered deer in such a manner that the tag cannot be removed without mutilating or destroying the tag. This tag shall be attached to the carcass of the deer within 15 minutes of the time the deer carcass is located after being taken or before the carcass is moved to be transported by any means from the place where the deer was taken, whichever occurs first. No person shall tag a deer with a transportation tag issued to another person or with a tag that was purchased after the deer was taken. During the youth/disabled hunter season, bow season, early muzzleloader season and late muzzleloader season, the hunter who killed the deer must tag the deer by using the transportation tag issued in that person's name. During the first and second regular gun seasons and the January antlerless-deer-only season, anyone present in the hunting party may tag a deer with a tag issued in that person's name. This tag shall be proof of possession and shall remain affixed to the carcass until such time as the animal is processed for consumption. The head, and antlers if any, shall remain attached to the deer while being transported by any means whatsoever from the place where taken to the processor or commercial preservation facility or until the deer has been processed for consumption.

[ARC 9717B, IAB 9/7/11, effective 10/12/11; ARC 0189C, IAB 7/11/12, effective 8/15/12]

571—106.10(481A) Youth deer and severely disabled hunts.

106.10(1) Licenses.

a. *Youth deer hunt.* A youth deer license may be issued to any Iowa resident who is not over 15 years old on the day the youth obtains the license. The youth license may be paid or free to persons eligible for free licenses. If the youth obtains a free landowner/tenant license, it will count as the one free any-deer license for which the youth's family is eligible.

Each participating youth must be accompanied by an adult who possesses a regular hunting license and has paid the habitat fee (if the adult is normally required to have a hunting license and to pay the habitat fee to hunt). Only one adult may participate for each youth hunter. The accompanying adult must not possess a firearm or bow and must be in the direct company of the youth at all times.

A person may obtain only one youth any-deer license but may also obtain any other paid or free any-deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner with which other hunters obtain them, as described in 106.6(2).

b. *Severely disabled hunt.* Any severely disabled Iowa resident meeting the requirements of Iowa Code section 321L.1(8) may be issued one any-deer license to hunt deer during the youth season. A person applying for this license must either possess a disability parking permit or provide a completed form from the department of natural resources. The form must be signed by a physician verifying that the person's disability meets the criteria defined in Iowa Code section 321L.1(8). Forms are available online at www.iowadnr.com, by visiting the DNR central office or any district office, or by calling (515)281-5918. A person between 16 and 65 years of age must also possess a regular hunting license and have paid the habitat fee to obtain a license (if normally required to have a hunting license and to pay the habitat fee to hunt). A severely disabled person obtaining this license may obtain any other paid and free any-deer and antlerless-deer-only licenses that are available to other hunters. Antlerless-deer-only licenses must be obtained in the same manner by which other hunters obtain them, as described in 106.6(2).

106.10(2) Season dates. Deer of either sex may be taken statewide for 16 consecutive days beginning on the third Saturday in September. A person who is issued a youth deer hunting license and does not take a deer during the youth deer hunting season may use the deer hunting license and unused tag during the early muzzleloader, late muzzleloader, and one of the shotgun seasons. The license will

be valid for the type of deer and in the area specified on the original license. The youth must follow all other rules specified in this chapter for each season. A youth hunting in one of the other seasons must obtain a hunting license and habitat stamp or hunt with a licensed adult if required by Iowa Code section 483A.24. If the tag is filled during one of the seasons, the license will not be valid in subsequent seasons.

106.10(3) *Shooting hours.* Legal shooting hours will be one-half hour before sunrise to one-half hour after sunset each day regardless of weapon used.

106.10(4) *Limits and license quotas.* An unlimited number of licenses may be issued. The daily and season bag and possession limit is one deer per license. A person may shoot and tag a deer only by utilizing the license and tag issued in the person's name.

106.10(5) *Method of take and other regulations.* Deer may be taken with shotgun, bow or muzzleloaded rifles as permitted in 571—106.7(481A). All participants must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122. All other regulations for obtaining licenses or hunting deer shall apply.

106.10(6) *Procedures for obtaining licenses.* Paid and free youth season licenses and licenses for severely disabled hunters may be obtained through ELSI beginning August 15 through the last day of the youth season.

571—106.11(481A) *Deer depredation management.* The deer depredation management program provides assistance to producers through technical advice and additional deer licenses and permits where the localized reduction of female deer is needed to reduce damage. Upon signing a depredation management agreement with the department, producers of agricultural or high-value horticultural crops may be issued deer depredation permits to shoot deer causing excessive crop damage. If immediate action is necessary to forestall serious damage, depredation permits may be issued before an agreement is signed. Further permits will not be authorized until an agreement is signed.

106.11(1) *Method of take and other regulations.* Legal weapons and restrictions will be governed by 571—106.7(481A). For deer shooting permits only, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93. The producer or designee must meet the deer hunters' orange apparel requirement in Iowa Code section 481A.122.

106.11(2) *Eligibility.* Producers growing typical agricultural crops (such as corn, soybeans, hay and oats and tree farms and other forestlands under a timber management program) and producers of high-value horticultural crops (such as Christmas trees, fruit or vegetable crops, nursery stock, and commercially grown nuts) shall be eligible to enter into depredation management agreements if these crops sustain excessive damage.

a. The producer may be the landowner or a tenant, whoever has cropping rights to the land.

b. Excessive damage is defined as crop losses exceeding \$1,000 in a single growing season, or the likelihood that damage will exceed \$1,000 if preventive action is not taken, or a documented history of at least \$1,000 of damage annually in previous years.

c. Producers who lease their deer hunting rights are not eligible for the deer depredation management program.

106.11(3) *Depredation management plans.* Upon request from a producer, field employees of the wildlife bureau will inspect and identify the type and amount of crop damage sustained from deer. If damage is not excessive, technical advice will be given to the producer on methods to reduce or prevent future damage. If damage is excessive and the producer agrees to participate, a written depredation management plan will be developed by depredation biologists in consultation with the producer.

a. The goal of the management plan will be to reduce damage to below excessive levels within a specified time period through a combination of producer-initiated preventive measures and the issuance of deer depredation permits.

(1) Depredation plans written for producers of typical agricultural crops may require preventive measures such as harassment of deer with pyrotechnics and cannons, guard dogs, and temporary fencing, as well as allowing more hunters, increasing the take of antlerless deer, and other measures that may prove effective.

(2) Depredation plans written for producers of high-value horticultural crops may include all of the measures in (1) above, plus permanent fencing where necessary. Fencing will not be required if the cost of a fence exceeds \$1,000.

(3) Depredation permits to shoot deer may be issued to Iowa residents to reduce deer numbers until long-term preventive measures become effective. Depredation permits will not be used as a long-term solution to deer damage problems.

b. Depredation management plans will normally be written for a three-year period with progress reviewed annually by the department and the producer.

(1) The plan will become effective when signed by the depredation biologist and the producer.

(2) Plans may be modified or extended if mutually agreed upon by the department and the producer.

(3) Depredation permits will not be issued after the initial term of the management plan if the producer fails to implement preventive measures outlined in the plan.

106.11(4) *Depredation permits.* Two types of permits may be issued under a depredation management plan.

a. Deer depredation licenses. Deer depredation licenses may be sold to resident hunters only for the regular deer license fee for use during one or more legal hunting seasons. Depredation licenses will be available to producers of agricultural and horticultural crops.

(1) Depredation licenses will be issued up to the number specified in the management plan.

(2) The landowner or an eligible family member, which shall include the landowner's spouse or domestic partner and juvenile children, may obtain one depredation license for each season established by the commission. No other individual may initially obtain more than three depredation licenses per management plan. When a deer is reported harvested on one of these licenses, then another license may be obtained.

(3) Depredation licenses will be valid only for hunting antlerless deer, regardless of restrictions that may be imposed on regular deer hunting licenses in that county.

(4) Hunters may keep any deer legally tagged with a depredation license.

(5) All other regulations for the hunting season specified on the license will apply.

(6) Depredation licenses will be valid only on the land where damage is occurring and the immediately adjacent property unless the land is within a designated block hunt area as described in subparagraph (7). Other parcels of land in the farm unit not adjacent to the parcels receiving damage will not qualify.

(7) Block hunt areas are areas designated and delineated by wildlife biologists of the wildlife bureau to facilitate herd reduction in a given area where all producers may not qualify for the depredation program or in areas of persistent deer depredation. Depredation licenses issued to producers within the block hunt area are valid on all properties within the delineated boundaries. Individual landowner permission is required for hunters utilizing depredation licenses within the block hunt area boundaries. Creation of a given block hunt area does not authorize trespass.

b. Deer shooting permits. Permits for shooting deer outside an established hunting season may be issued to producers of high-value horticultural crops when damage cannot be controlled in a timely manner during the hunting seasons (such as late summer buck rubs in an orchard and winter browsing in a Christmas tree plantation) and to other agricultural producers who have an approved DNR deer depredation plan, and on areas such as airports where public safety may be an issue.

(1) Deer shooting permits will be issued at no cost to the applicant.

(2) The applicant or one or more designees approved by the department may take all the deer specified on the permit.

(3) Permits available to producers of high-value horticultural crops or agricultural crops may be valid for taking deer outside of a hunting season depending on the nature of the damage. The number and type of deer to be killed will be determined by a department depredation biologist and will be part of the deer depredation management plan.

(4) Permits issued due to public safety concerns may be used for taking any deer, as necessary, to address unpredictable intrusion which could jeopardize public safety. Permits may be issued for an entire year (January 1 through December 31) if the facility involved signs an agreement with the department.

- (5) All deer killed must be recovered and processed for human consumption.
- (6) The times, dates, place and other restrictions on the shooting of deer will be specified on the permit.
- (7) Antlers from all deer recovered must be turned over to the conservation officer within 48 hours. Antlers will be disposed of according to department rules.
- (8) For out-of-season shooting permits, there are no shooting hour restrictions; however, taking deer with an artificial light is prohibited by Iowa Code section 481A.93.
 - c. Depredation licenses and shooting permits will be issued in addition to any other licenses for which the hunters may be eligible.
 - d. Depredation licenses and shooting permits will not be issued if the producer restricts the legal take of deer from the property sustaining damage by limiting hunter numbers below levels required to control the deer herd. This restriction does not apply in situations where shooting permits are issued for public safety concerns.
 - e. A person who receives a depredation permit pursuant to this paragraph shall pay a \$1 fee for each license that shall be used and is appropriated for the purpose of deer herd population management, including assisting with the cost of processing deer donated to the help us stop hunger (HUSH) program administered by the commission and a \$1 writing fee for each license to the license agent.

106.11(5) Disposal. Rescinded IAB 7/16/08, effective 8/20/08.
 [ARC 7921B, IAB 7/1/09, effective 8/5/09]

571—106.12(481A) Eligibility for free landowner/tenant deer licenses.

106.12(1) Who qualifies for free deer hunting licenses.

a. Owners and tenants of a farm unit and the spouse and juvenile child of an owner or tenant who reside with the owner or tenant are eligible for free deer licenses. The owner or tenant does not have to reside on the farm unit but must be actively engaged in farming it. Nonresident landowners do not qualify.

b. Juvenile child defined. “Juvenile child” means a person less than 18 years of age or a person who is 18 or 19 years of age and is in full-time attendance at an accredited school pursuing a course of study leading to a high school diploma or a high school equivalency diploma. A person 18 years of age or older who has received a high school diploma or high school equivalency diploma does not qualify.

106.12(2) Who qualifies as a tenant. A “tenant” is a person other than the landowner who is actively engaged in the operation of the farm. The tenant may be a member of the landowner’s family, including in some circumstances the landowner’s spouse or child, or a third party who is not a family member. The tenant does not have to reside on the farm unit.

106.12(3) What “actively engaged in farming” means. Landowners and tenants are “actively engaged in farming” if they personally participate in decisions about farm operations and those decisions, along with external factors such as weather and market prices, determine their profit or loss for the products they produce. Tenants qualify if they farm land owned by another and pay rent in cash or in kind. A farm manager or other third party who operates a farm for a fee or a laborer who works on the farm for a wage and is not a family member does not qualify as a tenant.

106.12(4) Landowners who qualify as active farmers. These landowners:

- a. Are the sole operator of a farm unit (along with immediate family members), or
- b. Make all decisions about farm operations, but contract for custom farming or hire labor to do some or all of the work, or
- c. Participate annually in decisions about farm operations such as negotiations with federal farm agencies or negotiations about cropping practices on specific fields that are rented to a tenant, or
- d. Raise specialty crops from operations such as orchards, nurseries, or tree farms that do not necessarily produce annual income but require annual operating decisions about maintenance or improvements, or
- e. May have portions of the farm enrolled in a long-term land retirement program such as the Conservation Reserve Program (CRP) as long as other farm operations occur annually, or

f. Place their entire cropland in the CRP or other long-term land retirement program with no other active farming operation occurring on the farm.

106.12(5) *Landowners who do not qualify.* These landowners:

a. Use a farm manager or other third party to operate the farm, or

b. Cash rent the entire farm to a tenant who is responsible for all farm operations including following preapproved operations plans.

106.12(6) *Where free licenses are valid.* A free license is valid only on that portion of the farm unit that is in a zone open to deer hunting. “Farm unit” means all parcels of land in tracts of two or more contiguous acres that are operated as a unit for agricultural purposes and are under lawful control of the landowner or tenant regardless of how that land is subdivided for business purposes. Individual parcels of land do not need to be adjacent to one another to be included in the farm unit. “Agricultural purposes” includes but is not limited to field crops, livestock, horticultural crops (e.g., from nurseries, orchards, truck farms, or Christmas tree plantations), and land managed for timber production.

106.12(7) *Registration of landowners and tenants.* Landowners and tenants and their eligible family members who want to obtain free deer hunting licenses must register with the department before the free licenses will be issued. Procedures for registering are described in 571—95.2(481A).

571—106.13(481A) Harvest reporting. Each hunter who bags a deer must report that kill according to procedures described in 571—95.1(481A).

571—106.14(481A) Extension to the regular gun seasons. Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.38, 481A.39, 481A.48, 483A.8, 483A.8B, 483A.8C, 483A.24 and 483A.24B.

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†See HJR 5 of 2003 Session of Eightieth General Assembly.

CHAPTER 108
MINK, MUSKRAT, RACCOON, BADGER, OPOSSUM, WEASEL,
STRIPED SKUNK, FOX (RED AND GRAY), BEAVER, COYOTE, RIVER OTTER,
BOBCAT, GRAY (TIMBER) WOLF AND SPOTTED SKUNK SEASONS

[Prior to 12/31/86, Conservation Commission[290] Ch 104]

571—108.1(481A) Mink, muskrat and weasel. Open season for the taking of mink, muskrat and weasel shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

108.1(1) *Molesting or disturbing muskrat houses.* Any department of natural resources officer, natural resource biologist, or county conservation board director may permit trappers to molest or disturb muskrat houses on specific state or county game management areas as provided in Iowa Code section 481A.90, after finding that muskrats are causing excessive damage by destroying the vegetation essential to the welfare of a marsh and after so posting the area.

108.1(2) *Game management areas.* Open season for taking muskrats on certain state game management areas, certain federal national wildlife refuges, and certain county conservation board areas, only where approved by the wildlife bureau and posted accordingly, shall be from 8 a.m. the day after the regular muskrat trapping season ends until April 1. The use of leg-hold traps during this season is prohibited unless each trap is placed completely inside a muskrat house. No bag or possession limit. [ARC 7933B, IAB 7/1/09, effective 8/5/09]

571—108.2(481A) Raccoon, badger, opossum and striped skunk. Open season for the taking of raccoon, badger, opossum, and striped skunk shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

571—108.3(481A) Red and gray fox. Open season for the taking of red and gray fox shall be from 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit.

571—108.4(481A) Beaver. Open season for the taking of beaver shall be from 8 a.m. on the first Saturday in November through April 15 of succeeding year. No bag or possession limit. [ARC 9654B, IAB 8/10/11, effective 9/14/11]

571—108.5(481A) Coyote.

108.5(1) *Hunting.* Continuous open season. Entire state open. No bag or possession limit.

108.5(2) *Trapping.* Open season for trapping coyote shall be 8 a.m. on the first Saturday in November through January 31 of succeeding year. Entire state open. No bag or possession limit. Any conservation officer or wildlife biologist may authorize a landowner, tenant or designee to trap coyotes causing damage outside the established trapping season dates.

571—108.6(481A) Gray (timber) wolf and spotted skunk. Continuous closed season.

571—108.7(481A) River otter and bobcat.

108.7(1) *License requirements.* Each person who takes river otters or bobcats shall have a valid fur harvester license and pay the habitat fee if normally required to have a license to hunt or trap.

108.7(2) *Open area.* River otters may be taken statewide. Bobcats may be taken in the following counties: Adair, Adams, Appanoose, Cass, Clarke, Davis, Decatur, Des Moines, Fremont, Guthrie, Harrison, Henry, Jefferson, Keokuk, Lee, Louisa, Lucas, Madison, Mahaska, Marion, Mills, Monona, Monroe, Montgomery, Page, Pottawattamie, Ringgold, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, and Woodbury.

108.7(3) *Quotas and seasonal bag limit.*

a. Seasonal bag limit. The seasonal bag limit is 3 river otters and 1 bobcat per person.

b. Quotas. The quota for the number of river otters that may be taken is 850 statewide. The quota for the number of bobcats that may be taken is 450 in the open area. The season shall end for river otters

when the number of river otters trapped, as determined by the harvest reporting system, reaches the quota. The season shall end for bobcats when the number of bobcats taken, as determined by the harvest reporting system, reaches the quota. Trappers shall be allowed a grace period that ends on midnight of the day after the quota is reached to clear their traps of river otters or bobcats. River otters or bobcats found in traps during the grace period may be kept even though the quota is exceeded provided that the trapper has not reached the trapper's personal bag limit. River otters or bobcats trapped after the grace period or in excess of the seasonal bag limit must be turned over to the department; the trapper shall not be penalized.

108.7(4) *Season dates.* The season for taking river otters and bobcats opens on the first Saturday in November and closes when the quota has been reached, as explained in this rule, or on January 31 of the following year, whichever occurs first.

108.7(5) *Reporting requirements.*

a. Anyone, including a landowner or tenant not required to have a fur harvester license, who takes a river otter or bobcat must report the harvest to a DNR conservation officer or designated DNR employee within 24 hours. The fur harvester must arrange to receive a CITES tag from the officer or designated DNR employee within seven days of the time the harvest is reported. The river otter or bobcat shall be skinned and the carcass turned over to the DNR conservation officer or designated DNR employee at the time the CITES tag is issued. If the specimen is to be kept whole for taxidermy purposes, a cut shall be made by the trapper between the gum line and eye so the CITES tag can be attached to the skin. It shall be the responsibility of the taxidermist to have the carcass turned over to a DNR conservation officer or designated DNR employee once that animal has been skinned for taxidermy purposes.

b. Upon receiving a telephone report that a river otter or bobcat has been legally taken, the conservation officer or DNR employee will call the department's harvest reporting system. The number of river otters and bobcats taken will be updated daily, and a message will be recorded on the department's telephone system. The number taken will be available 24 hours a day. Fur harvesters may check the message daily to determine when the season closes and when the grace period begins and ends. The department will use all practical means to publicize these dates.

108.7(6) *Tagging requirements.* Every river otter or bobcat that may legally be kept must have a CITES tag attached. Tags will be supplied by the conservation officer or designated DNR employee. The tag must remain with the pelt until the pelt is sold or used for other purposes that render it no longer available for sale. Persons displaying river otters or bobcats as taxidermy mounts or as other decorative items must keep the tags in their possession as proof of legal harvest.

[ARC 7933B, IAB 7/1/09, effective 8/5/09; ARC 8889B, IAB 6/30/10, effective 8/18/10; ARC 9654B, IAB 8/10/11, effective 9/14/11; ARC 0188C, IAB 7/11/12, effective 8/15/12]

571—108.8(481A) *Accidental capture of a river otter or bobcat during a closed season.* A person who accidentally captures a river otter or bobcat during a closed season or in a closed area or after the person's individual bag limit has been reached shall not be penalized provided that:

1. The river otter or bobcat is captured during a legal trapping season or as part of a legal depredation control process; and

2. A conservation officer is contacted within 24 hours and the river otter or bobcat and all parts thereof are turned over to a conservation officer as soon as practical.

571—108.9(481A) *Trapping restrictions.* Trapping for all furbearers will be restricted as follows:

108.9(1) *Exposed bait.* No person shall set or maintain any leghold, body-clasping trap, or snare within 20 feet of exposed bait on land anywhere in the state or over water in the following areas:

a. Mississippi River corridor—Allamakee, Clayton, Dubuque, Jackson, Clinton, Scott, Muscatine, Louisa, Des Moines and Lee Counties.

b. Missouri River corridor—Those portions of Woodbury, Monona, Harrison, Pottawattamie, Mills and Fremont Counties west of Interstate 29.

c. Des Moines River corridor—Boone, Dallas, Polk, Marion, Mahaska, Wapello and Van Buren Counties.

Exposed bait means meat or viscera or any animal, bird, fish, amphibian, or reptile with or without skin, hide, or feathers visible to soaring birds.

108.9(2) *Trapping near beaver lodges and dens.* Rescinded IAB 7/16/08, effective 8/20/08.

These rules are intended to implement Iowa Code sections 481A.6, 481A.38, 481A.39, 481A.87, and 481A.90.

These rules are based on the best biological data available as determined by research conducted by the department of natural resources.

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TRANSPORTATION DEPARTMENT[761]

Rules transferred from agency number [820] to [761] to conform with the reorganization numbering scheme in general IAC Supp. 6/3/87.

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761—25.1(23A) Interpretation. This chapter shall not be interpreted to mean that the department must provide a good or service or will provide a good or service without qualification, restriction, or charge.

761—25.2(23A) Exemptions. Activities related to the items listed in this rule are exempted from the provisions of Iowa Code section 23A.2, subsection 1.

25.2(1) Transportation-related printing, publications and electronically generated materials including, but not limited to: forms; brochures; booklets; manuals; directories; periodicals; county, city and state transportation maps; video and audio materials; computer tapes and discs; microfilm and other instructional and informative materials.

25.2(2) Copies of records or other services provided to meet the requirements of Iowa Code chapter 22.

25.2(3) Transportation-related studies, planning and research.

25.2(4) Disposal of surplus, obsolete or junked materials and supplies and equipment.

25.2(5) Matters of intergovernmental cooperation. Cooperating with other government bodies does not involve providing goods or services to the public except in the broadest sense. The term “government bodies” includes regional transit systems. Activities which involve intergovernmental cooperation include, but are not limited to, the following:

a. Use or consumption of departmental facilities, equipment, materials or supplies by other government bodies, including loans, rentals and sales of equipment, materials and supplies.

b. Services provided to or performed for other government bodies. These services include:

(1) Vehicle maintenance and repair services provided to other state agencies.

(2) Purchasing services provided to other government bodies.

(3) Purchases made by other government bodies through state contracts.

(4) Disposal of surplus, obsolete or junked materials and supplies and equipment belonging to other state agencies, counties or cities.

(5) Other services performed for government bodies. These services cover a wide range of activities and are performed primarily for county and city highway departments, agencies having park or institutional roads, county treasurers, public transit systems, publicly owned airports, law enforcement agencies, regional planning agencies, and transportation-related boards.

25.2(6) Acquisition and disposal of land and improvements acquired for highways or facilities use.

25.2(7) Lease of right-of-way.

25.2(8) Design, construction, reconstruction, inspection and maintenance of highways including, but not limited to, signs erected in the right-of-way and acknowledgment signs used in the adopt-a-highway, rest area sponsorship and highway helper sponsorship programs.

25.2(9) State aircraft pool operations.

25.2(10) Use or consumption of specialized departmental equipment, materials, supplies or services to complete a contract with the department if the goods or services are not readily available on the open market and the department can provide the goods or services at a competitive price.

25.2(11) Use of departmental facilities to complete a contract with the department.

25.2(12) Activities related to emergencies including, but not limited to, providing assistance to the public.

25.2(13) Goods or services for use or consumption by the department.

25.2(14) Use of departmental facilities or services by persons providing services to or representing departmental employees including, but not limited to, the following services or persons: food, credit union, day care and employee organizations.

25.2(15) Use of departmental conference rooms or grounds by civic groups and nonprofit organizations.

25.2(16) Personal protective items purchased by departmental employees through state contracts.

25.2(17) Goods or services promoting transportation or transportation safety.

25.2(18) Any other activity permitted or required by law.
[ARC 0187C, IAB 7/11/12, effective 8/15/12]

These rules are intended to implement Iowa Code sections 23A.1 and 23A.2.

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[Filed ARC 0187C (Notice ARC 0113C, IAB 5/2/12), IAB 7/11/12, effective 8/15/12]

CHAPTER 123
REST AREA SPONSORSHIP PROGRAM

761—123.1(307) Introduction and purpose. The rest area sponsorship program is an exchange of a monetary contribution from a person, a firm, or an entity for public recognition in the form of identification displayed on an acknowledgment sign on the main-traveled way of an interstate highway in advance of the exit for a rest area and an interior sign within the primary rest area building. The purpose of the program is to provide contributory support for the primary road fund. The rest areas are funded through the primary road fund and provide a public service.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—123.2(307) Contact information. Information relating to the issuance of requests for proposals when sponsorship opportunities become available may be obtained from the Office of Maintenance, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010, or by telephone at (515)239-1971.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—123.3(307) Definitions. As used in this chapter, unless the context otherwise requires:

“Acknowledgment sign” means an official sign placed within the right-of-way which meets all design and placement guidelines for acknowledgment signs as covered in Part 2 of the MUTCD, and all sign design principles covered in the most current edition of the “Standard Highway Signs and Markings Book,” as published by the U.S. Department of Transportation, Federal Highway Administration, and which is intended only to inform the traveling public that a highway-related service, product or monetary contribution has been sponsored by a person, firm or entity.

“Advertise” means to provide information on a sign which includes, but is not limited to, any of the following: promotional offers, location directions, a listing of amenities, descriptive words or phrases, telephone numbers, Internet addresses including domain names, slogans or any message that is extraneous to the identification of a single-sponsoring person, firm or entity.

“Identification” means a display on an acknowledgment sign which is limited to the name of the sponsor or a registered or unregistered trademark in addition to or instead of the name of the sponsor, if such mark is used consistently by the sponsor whenever and wherever the firm’s or entity’s name is visible to the public, and the medium will allow. If multiple trademarks are used by the sponsor, identification is provided only by the one in the simplest form needed to identify the sponsor.

“Interstate highway” means any highway of the primary system at any time officially designated as a part of the national system of interstate and defense highways by the department and approved by the appropriate authority of the federal government.

“Main-traveled way” means the portion of the roadway for movement of vehicles on which through traffic is carried, exclusive of shoulders and auxiliary lanes. In the case of a divided highway, the main-traveled way includes each of the separated roadways for traffic in opposite directions, exclusive of frontage roads, turning roadways or parking areas.

“MUTCD” means the Manual on Uniform Traffic Control Devices as adopted in 761—Chapter 130.

“Rest area” means an area or site established and maintained within or adjacent to the right-of-way of an interstate, freeway-primary or primary highway under supervision and control of the department for the safety, recreation, and convenience of the traveling public. Subject to paragraph 123.4(1) “b,” if two rest areas are located in close proximity and serve opposite directions of travel, both rest areas are individually eligible for sponsorship.

“Right-of-way” means land area dedicated to public use for the highway and its maintenance, and includes land acquired in fee simple or by permanent easement for highway purposes, but does not include temporary easements or rights for supplementary highway appurtenances.

“Sponsor” means a single person, firm or entity which has been approved by the department for the rest area sponsorship program.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—123.4(307) General provisions.**123.4(1) Scope.**

a. This program is limited to the sponsorship of all rest areas located on the interstate highways in Iowa.

b. This program may be limited by the department to those rest areas located in areas where adequate spacing for acknowledgment signs along the main-traveled way is available, in accordance with the MUTCD, Section 2H.08, “Acknowledgment Signs.”

123.4(2) Authority and conditions.

a. Subject to the provisions of Iowa Code section 321.253, the department may erect in advance of the exit for the rest area one acknowledgment sign per rest area, per direction of travel, on the interstate highway right-of-way along the main-traveled way.

b. The department may allow an interior sign, with size and message approved by the department, within the primary building which may advertise the sponsor.

c. Subject to the provisions of Iowa Code chapter 23A, the department may, through an equitable procurement process, receive a monetary contribution from an approved sponsor. This monetary contribution shall be deposited into the primary road fund and subsequently spent for highway purposes, including the maintenance and operation of the rest areas.

d. The department shall have the right to discontinue the program, or portions thereof, if the program or any component part of the program is found to be in violation of federal law or regulation.

e. The department shall have the right to terminate a sponsorship agreement for reasons, as determined by the department, based on safety concerns, interference with the free and safe flow of traffic, or a determination that the sponsorship agreement or acknowledgment sign is not in the public interest.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—123.5(307) Sponsorship agreements.

123.5(1) Federal Highway Administration approval. All sponsorship agreements are subject to approval by the Federal Highway Administration.

123.5(2) Qualifications. A person, firm or entity may be eligible to participate as a sponsor for the program. However, the department may deny the proposal or application from any potential sponsor if the sponsor’s participation might be deemed by the state as a partisan endorsement or have an adverse effect on the program.

123.5(3) Selection process. Sponsors will be approved through a fair and transparent procurement process, as approved by the department, subject to the provisions of 761—Chapter 20.

123.5(4) Discrimination prohibited. As a condition of approval as a sponsor, the sponsor shall give the department written assurance of the sponsor’s conformity with all applicable laws prohibiting discrimination based on age, race, creed, color, sex, sexual orientation, gender identity, national origin, religion or disability.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—123.6(307) Acknowledgment sign criteria.**123.6(1) Identification displayed.**

a. An acknowledgment sign shall not advertise.

b. An acknowledgment sign shall not contain any messages, lights, symbols or trademarks that resemble any official traffic control device.

c. An acknowledgment sign shall contain the appropriate lettering to indicate “REST AREA” and may contain an identification of one sponsor.

d. The department shall review the acknowledgment sign proposed by the sponsor and shall have full authority to determine whether proposed designs from sponsors advertise or provide identification.

e. The department shall not approve any acknowledgment sign proposed by the sponsor if the sign might be deemed a partisan endorsement or have an adverse effect on the program.

123.6(2) *Design and placement of acknowledgment sign.*

a. The department shall determine when adequate spacing is available to accommodate the placement of an acknowledgment sign in accordance with the MUTCD.

b. The entire sign display area shall not exceed 24 square feet.

c. The area reserved for the identification of the sponsor shall not exceed one-third of the total area of the sign, shall be a maximum of 8 square feet, and shall not be located at the top of the sign.

d. Sponsors must provide signs measuring 24 inches high and 48 inches wide that are fabricated from .080 aluminum with 2-inch radius corners and have a ½-inch white border for placement on the acknowledgment signs.

e. The department shall inspect signs received from sponsors, and if the signs meet the requirements contained in this rule, the department shall perform the installation.

f. All acknowledgment signs erected by the department shall conform to the MUTCD.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

These rules are intended to implement Iowa Code subsection 23A.2(9) and Iowa Code section 307.24.

[Filed ARC 0187C (Notice ARC 0113C, IAB 5/2/12), IAB 7/11/12, effective 8/15/12]

CHAPTER 124
HIGHWAY HELPER SPONSORSHIP PROGRAM

761—124.1(307) Introduction and purpose. The department operates the highway helper sponsorship program on the primary highways to keep traffic flowing by providing minor breakdown assistance and aiding with traffic control at crash scenes. This chapter establishes the requirements for a sponsorship for this program. The purpose of this sponsorship program is to provide contributory support for the primary road fund. The highway helper fleet is funded through the primary road fund and provides a public service.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—124.2(307) Contact information. Information relating to the issuance of requests for proposals when sponsorship opportunities become available may be obtained from the Office of Traffic and Safety, Iowa Department of Transportation, 800 Lincoln Way, Ames, Iowa 50010, or by telephone at (515)239-1296.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—124.3(307) Definitions. As used in this chapter, unless the context otherwise requires:

“Acknowledgment sign” means an official sign placed within the right-of-way which meets all design and placement guidelines for acknowledgment signs as covered in Part 2 of the MUTCD, and all sign design principles covered in the most current edition of the “Standard Highway Signs and Markings Book,” as published by the U.S. Department of Transportation, Federal Highway Administration, and which is intended only to inform the traveling public that a highway-related service, product or monetary contribution has been sponsored by a person, firm or entity.

“Advertise” means to provide information on a sign which includes, but is not limited to, any of the following: promotional offers, location directions, a listing of amenities, descriptive words or phrases, telephone numbers, Internet addresses including domain names, slogans or any message that is extraneous to the identification of a single-sponsoring person, firm or entity.

“Freeway-primary highway” means those highways under department jurisdiction which have been constructed as a fully controlled access facility with no access to the facility except at established interchanges.

“Highway helper vehicle” means a motor vehicle included in the program as designated by the department.

“Identification” means a display on an acknowledgment sign which is limited to the name of the sponsor or a registered or unregistered trademark in addition to or instead of the name of the sponsor, if such mark is used consistently by the sponsor whenever and wherever the firm’s or entity’s name is visible to the public, and the medium will allow. If multiple trademarks are used by the sponsor, identification is provided only by the one in the simplest form needed to identify the sponsor.

“Interstate highway” means any highway of the primary system at any time officially designated as a part of the national system of interstate and defense highways by the department and approved by the appropriate authority of the federal government.

“Main-traveled way” means the portion of the roadway for movement of vehicles on which through traffic is carried, exclusive of shoulders and auxiliary lanes. In the case of a divided highway, the main-traveled way includes each of the separated roadways for traffic in opposite directions, exclusive of frontage roads, turning roadways or parking areas.

“MUTCD” means the Manual on Uniform Traffic Control Devices as adopted in 761—Chapter 130.

“Right-of-way” means land area dedicated to public use for the highway and its maintenance, and includes land acquired in fee simple or by permanent easement for highway purposes, but does not include temporary easements or rights for supplementary highway appurtenances.

“Sponsor” means a single person, firm or entity which has been approved by the department for the highway helper sponsorship program. If the highway helper sponsorship program includes more than one urban area, this definition shall not preclude the approval of one sponsor per urban area.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—124.4(307) General provisions.

124.4(1) *Program ownership and operation.* The department shall retain ownership and operation of the highway helper program.

124.4(2) *Monetary contributions.* Subject to the provisions of Iowa Code chapter 23A, the department may, through an equitable procurement process, receive a monetary contribution from an approved sponsor. This monetary contribution shall be deposited into the primary road fund and subsequently spent for highway purposes, including the maintenance and operation of the highway helper sponsorship program.

124.4(3) *Placement of signs.* Subject to the provisions of Iowa Code section 321.253, the department may erect acknowledgment signs within the right-of-way along the main-traveled way of any interstate or freeway-primary highway patrolled by the highway helper vehicles.

124.4(4) *Program discontinuance.* The department shall have the right to discontinue the program, or portions thereof, if the program or any component part of the program is found to be in violation of federal law or regulation.

124.4(5) *Termination of sponsorship agreement.* The department shall have the right to terminate a sponsorship agreement for reasons, as determined by the department, based on safety concerns, interference with the free and safe flow of traffic, or a determination that the sponsorship agreement or acknowledgment sign is not in the public interest.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—124.5(307) Sponsorship agreements.

124.5(1) *Federal Highway Administration approval.* All sponsorship agreements are subject to approval by the Federal Highway Administration.

124.5(2) *Qualifications.* A person, firm or entity may be eligible to participate as a sponsor for the program. However, the department may deny the proposal or application from any potential sponsor if the sponsor's participation might be deemed by the state as a partisan endorsement or have an adverse effect on the program.

124.5(3) *Selection process.* Sponsors will be approved through a fair and transparent procurement process, as approved by the department, subject to the provisions of 761—Chapter 20.

124.5(4) *Sponsor benefits.* Subject to terms mutually agreed upon by the department and sponsor during or following the procurement process, the following benefits may be offered:

a. Identification of the sponsor on acknowledgment signs along the interstate or freeway-primary highway, subject to rule 761—124.6(307).

b. Placement of the sponsor's name and logo on a highway helper vehicle, not to exceed the dimension and size requirements for the particular highway helper vehicle, as determined by the department.

124.5(5) *Discrimination prohibited.* As a condition of approval as a sponsor, the sponsor shall give the department written assurance of the sponsor's conformity with all applicable laws prohibiting discrimination based on age, race, creed, color, sex, sexual orientation, gender identity, national origin, religion or disability.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

761—124.6(307) Acknowledgment sign criteria.

124.6(1) *Identification displayed.*

a. An acknowledgment sign shall not advertise.

b. An acknowledgment sign shall not contain any messages, lights, symbols or trademarks that resemble any official traffic control device.

c. An acknowledgment sign shall contain the appropriate lettering to indicate "HIGHWAY HELPER" and may contain an identification of one sponsor.

d. The department shall review the acknowledgment sign proposed by the sponsor and shall have full authority to determine whether proposed designs from sponsors advertise or provide identification.

e. The department shall not approve any acknowledgment sign proposed by the sponsor if the sign might be deemed a partisan endorsement or have an adverse effect on the program.

124.6(2) *Design and placement of acknowledgment sign.*

a. The department shall determine when adequate spacing is available to accommodate the placement of an acknowledgment sign in accordance with the MUTCD.

b. No more than one acknowledgment sign per interstate or freeway-primary route per direction shall be installed within an urban area. If routes run concurrently, each route may be afforded one acknowledgment sign per direction, at the department's discretion.

c. The entire sign display area shall not exceed 24 square feet.

d. The area reserved for the identification of the sponsor shall not exceed one-third of the total area of the sign, shall be a maximum of 8 square feet, and shall not be located at the top of the sign.

e. Sponsors must provide signs measuring 24 inches high and 48 inches wide that are fabricated from .080 aluminum with 2-inch radius corners and have a ½-inch white border for placement on the acknowledgment signs.

f. The department shall inspect signs received from sponsors, and if the signs meet the requirements contained in this rule, the department shall perform the installation.

g. All acknowledgment signs erected by the department shall conform to the MUTCD.

These rules are intended to implement Iowa Code subsection 23A.2(9) and Iowa Code section 307.24.

[ARC 0187C, IAB 7/11/12, effective 8/15/12]

[Filed ARC 0187C (Notice ARC 0113C, IAB 5/2/12), IAB 7/11/12, effective 8/15/12]