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

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

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

INSTRUCTIONS

FOR UPDATING THE

IOWA ADMINISTRATIVE CODE

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

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CHAPTER 35
IDENTITY THEFT PASSPORT

61—35.1(715A) Definitions.

"Creditor" means a person or entity who is owed money or property by another person via the extension of credit to that other person to defer payment of debt, to incur debt and defer its payment, or to purchase property or services and defer payment therefor, or a person or entity to whom a creditor's right to payment has been assigned.

"Division" means the crime victim assistance division in the attorney general's office.

"Division director" means the director of the crime victim assistance division in the attorney general's office.

"Identity theft" means the commission of the offense of identity theft, as stated in Iowa Code section 715A.8(2), which includes when a person fraudulently uses or attempts to fraudulently use identification information of another person, with the intent to obtain credit, property, services, or other benefit.

"Law enforcement agency" means an agency that employs peace officers.

"Peace officer" means the same as defined in Iowa Code section 801.4(11).

"Person" means an individual.

"Report of identity theft" means a request by a person to a peace officer in any jurisdiction described in Iowa Code section 715A.8(5) for the peace officer to take a report regarding an alleged commission of identity theft against the person.

"Victim" means a person who alleges that identity theft has been committed against the person.

[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

61—35.2(715A) Application for identity theft passports.

35.2(1) *Completion of application.*

a. A person who has filed a report of identity theft may apply for an identity theft passport through the law enforcement agency to which the report was made.

b. An application for an identity theft passport shall include the following:

(1) Completion by the person, or by another on behalf of the person, and by the law enforcement agency, of the identity theft passport application form and the identity theft verification form set out in rule 61—35.8(715A), along with any documentation supporting the claim that the person is a victim of identity theft.

(2) A copy of the report of identity theft made to the law enforcement agency.

(3) Photographic identification of the victim in one of the following formats in order of preference:

1. A copy of the victim's current driver's license or state-issued nonoperator's identification card.

2. A current photograph of the victim certified as valid by signature of the law enforcement investigator who received the report of identity theft.

c. Upon completion of the application for an identity theft passport, the law enforcement agency which received the application shall forward it to the crime victim assistance division of the office of the attorney general.

35.2(2) *Confidentiality of application.* An application made with the attorney general shall be confidential and shall not be a public record subject to disclosure under Iowa Code chapter 22.

[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

61—35.3(715A) Issuance of identity theft passports.

35.3(1) Upon receipt of a completed application for an identity theft passport, the division shall review the application and determine whether to issue the applicant an identity theft passport. In determining whether to issue the identity theft passport, the division shall consider all the facts and circumstances reported in the application, any recommendations received from the law enforcement agency to which the report was made, and any other facts that the division deems necessary to make the determination.

35.3(2) An identity theft passport shall be in the form of a card or certificate as determined by the attorney general.
[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

61—35.4(715A) Usage of identity theft passports. An identity theft victim may present the passport to:

35.4(1) A law enforcement agency to help prevent the victim's arrest or detention for any offense committed by someone other than the victim who is using the victim's identity, and

35.4(2) A creditor of the victim to aid in the creditor's investigation and establishment of whether fraudulent charges were made against accounts in the victim's name or whether accounts were opened using the victim's identity.
[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

61—35.5(715A) Acceptance of identity theft passports. A law enforcement agency or creditor may accept an identity theft passport from the victim and may consider the surrounding circumstances and available information regarding the offense of identity theft pertaining to the victim.
[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

61—35.6(715A) Expiration of identity theft passports. An identity theft passport issued by the office of the attorney general shall be valid for a period of five years from the date of issuance or renewal. The victim to whom an expired identity theft passport was issued may reapply to the office of the attorney general for renewal of the identity theft passport within 30 days after its expiration. The office of the attorney general may renew the identity theft passport in the same manner that initial passports are issued, as outlined in rule 61—35.3(715A).
[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

61—35.7(715A) Revocation of identity theft passports.

35.7(1) If the division determines that an identity theft passport which has been issued should not have been issued, the division shall notify the person to whom the identity theft passport was issued of the intended revocation of the identity theft passport and the reasons for the intended revocation.

35.7(2) The person who has received a notice of intended revocation of an identity theft passport may request reconsideration of the intended revocation. The request and all information in support of a reconsideration of the intended revocation shall be submitted to the division director within 30 calendar days of the mailing date on the notice of intended revocation.

35.7(3) The division director will issue a decision regarding the reconsideration of the intended revocation of the identity theft passport within 30 days of receipt of the request for reconsideration whenever possible. The decision of the division director regarding the revocation of the identity theft passport constitutes final agency action.

35.7(4) If, after notice, the division determines that the identity theft passport is revoked, the division shall notify the person of the revocation in a mailing to the person's last-known residential address.

35.7(5) A person shall not use a revoked identity theft passport for any purpose.
[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

61—35.8(715A) Identity theft passport application and verification forms.

35.8(1) *Identity theft victim application and affidavit.* The following form may be used to apply for an identity theft passport.

Iowa Attorney General's Office
Identity Theft Victim Application and Affidavit

Iowa Code section 715A.9A(2): A victim who has filed a report of identity theft with a law enforcement agency may apply for an identity theft passport through the law enforcement agency. The law enforcement agency shall send a copy of the police report and the application to the attorney general, who shall process the application and supporting report and may issue the victim an identity theft passport in the form of a card or certificate.

Section I: Victim Information

a. Full given name: _____

b. Common use name: _____

c. Aliases: _____

d. Birth date: _____ e. Social Security Number: _____

f. Driver's License Number: _____

g. Street address: _____

h. City: _____ State: _____ Zip Code: _____

i. Your home telephone number: _____

Section II: Crime Information

a. Date(s) of identity theft: _____

b. Item(s) stolen: _____

c. Location of crime: _____ d. Date(s) reported: _____

e. Law Enforcement Agency: _____

f. Name of suspect, if known: _____

g. Relationship of suspect to victim: _____

h. Other information (use additional page(s) if necessary): _____

_____

Section III: Other Information to Be Supplied Before a Passport May Be Issued

a. A copy of the victim's current driver's license or state-issued nonoperator's identification card; or, if neither is available,

b. A current photograph of the victim certified as valid by signature of the law enforcement investigator who received the report of identity theft.

By signing this affidavit, I attest that the information provided above is true and accurate. I acknowledge that I did file an accurate and true law enforcement report of this incident(s).

_____ _____

Signature Date

35.8(2) *Identity theft law enforcement report verification.* The following form must be completed by the investigating officer and submitted in conjunction with the identity theft application and affidavit.

Iowa Attorney General's Office
Identity Theft Law Enforcement Report Verification

Iowa Code section 715A.9A(5): An application made with the attorney general under subsection 2, including any supporting documentation, shall be confidential and shall not be a public record subject to disclosure under chapter 22.

Section I: Law Enforcement Agency

a. Name of Law Enforcement Agency: _____

b. Law Enforcement Agency telephone number: _____

c. Name of Investigating Officer completing this report: _____

Section II: Information Requested from Law Enforcement Agency

a. Did the victim named in the attached Identity Theft Application and Affidavit report to your law enforcement agency the crime of identity theft? ☐Yes ☐No

b. Date of report: _____ c. LE case number: _____

d. Has a suspect been identified? ☐Yes ☐No

e. If yes, name of suspect: _____

f. Have charges been filed? _____

g. Is issuance of an Identity Theft Passport warranted in this case? ☐Yes ☐No

h. Other information (use additional paper if necessary): _____

_____

_____ _____

Signature of Investigating Officer Date

35.8(3) *Submission of documentation.* In order to be considered for an identity theft passport, a victim must submit the following documentation to the Crime Victim Assistance Division, Ground Floor, Lucas State Office Building, Des Moines, Iowa 50319:

a. The Identity Theft Victim Application and Affidavit form, signed by the victim.

b. The Identity Theft Law Enforcement Report Verification form, signed by the investigating officer.

c. A copy of the law enforcement agency's investigative report.

[**ARC 7940B**, IAB 7/15/09, effective 8/19/09]

These rules are intended to implement Iowa Code section 715A.9A.

[Filed ARC 7940B (Notice ARC 7528B, IAB 1/28/09), IAB 7/15/09, effective 8/19/09]

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[Prior to 10/22/86, see Insurance Department[510], renamed Insurance Division[191] under the "umbrella" of Department of Commerce by the 1986 Iowa Acts, Senate File 2175]

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[Prior to 10/22/86, Insurance Department[510]]

DIVISION I
SALES PRACTICES

191—15.1(507B) Purpose. This chapter is intended to establish certain minimum standards and guidelines of conduct by identifying unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, as prohibited by Iowa Code chapter 507B.

191—15.2(507B) Definitions.

"Advertisement" for the purpose of these rules shall be material designed to create public interest in insurance or an insurer, or to induce the public to purchase, increase, modify, reinstate or retain a policy including:

1. Printed and published material, audio and visual material, and descriptive literature of an insurer or producer used in direct mail, newspapers, magazines, radio scripts, TV scripts, billboards, computer on-line networks and similar displays; descriptive literature and sales aids of all kinds issued by an insurer or producer for presentation to members of the public, including but not limited to circulars, leaflets, booklets, depictions, illustrations, and form letters; and sales talks, presentations, and material for use by producers.
2. However, for the purpose of these rules "advertisement" shall not include: communications or materials used within an insurer's own organization and not intended for dissemination to the public; communications with policyholders other than material urging policyholders to purchase, increase, modify, reinstate, or retain a policy; and a general announcement from a group or blanket policyholder to eligible individuals on an employment or membership list that a policy or program has been written or arranged, provided the announcement clearly indicates that it is preliminary to the issuance of a booklet explaining the proposed coverage.

"Aftermarket crash parts" means replacement parts as defined in Iowa Code section 537B.4.

"Certificate" means a statement of the coverage and provisions of a policy of group accident and sickness insurance which has been delivered or issued for delivery in this state and includes riders, endorsements and enrollment forms, if attached.

"Duplicate Medicare supplement insurance" shall mean the sale or the attempt to knowingly sell to an individual a policy of insurance designed to supplement Medicare benefits as provided in The Health Insurance for the Aged Act, Title XVII of the Social Security Amendments of 1965 as then constituted or later amended when the individual is already insured under such a policy.

"Duplication" means policies of the same coverage type according to minimum standards classifications outlined in 191 IAC 36.6(514D) which overlap to the extent that a reasonable individual would not consider the ownership of the policies to be beneficial.

"Exception" for the purpose of these rules shall mean any provision in a policy whereby coverage for a specified hazard is entirely eliminated; it is a statement of a risk not assumed under the policy.

"Illustrated scale" shall mean a scale of nonguaranteed elements currently being illustrated that is not more favorable to the policyholder than the lesser of the disciplined current scale or the currently payable scale as defined in 191 IAC 14.4(507B).

"Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of accident and sickness insurance, or the promotion of the insurer as a seller of accident and sickness insurance.

"Insurer" shall mean any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's, fraternal benefit society, and any other legal entity engaged in the business of insurance.

"Invitation to contract" means an advertisement for accident and sickness insurance that is neither an invitation to inquire nor an institutional advertisement.

"Invitation to inquire" means an advertisement having as its objective the creation of a desire to inquire further about accident and sickness insurance and that is limited to a brief description of the loss

for which benefits are payable. An invitation to inquire may not refer to cost but may contain the dollar amount of benefits payable and the period of time during which benefits are payable.

"Limitation" for the purpose of these rules shall mean any provision which restricts coverage under the policy other than an exception or a reduction.

"Limited benefit health coverage" shall have the same meaning as defined in 191—subrule 36.6(10).

"Person" shall mean any individual, corporation, association, partnership, reciprocal exchange, interinsurer, fraternal benefit society, and any other legal entity engaged in the business of insurance, including insurance producers and adjusters. "Person" shall also mean any corporation operating under the provisions of Iowa Code chapter 514 and any benevolent association as defined and operated under Iowa Code chapter 512A. For purposes of this chapter, corporations operating under the provisions of Iowa Code chapter 514 and Iowa Code chapter 512A shall be deemed to be engaged in the business of insurance.

"Policy" shall include any policy, plan, certificate, contract, agreement, statement of coverage, rider, or endorsement which provides for insurance benefits.

"Preneed funeral contract or prearrangement" shall mean an agreement by or for an individual before the individual's death relating to the purchase or provision of specific funeral or cemetery merchandise or services.

"Producer" shall mean a person who solicits, negotiates, effects, procures, delivers, renews, continues or binds policies of insurance for risks residing, located or to be performed in this state.

"Prominently" or *"conspicuously"* means that the information to be disclosed will be presented in a manner that is noticeably set apart from other information or images in the advertisement.

"Reduction" for the purpose of these rules shall mean any provision which reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of such loss is limited to some amount or period less than would be otherwise payable had such reduction not been used.

"Twisting" shall mean any action by a producer or insurer to induce or attempt to induce any individual to lapse, forfeit, surrender, terminate, retain, assign, borrow, or convert a policy or an annuity in order that such individual procure another policy or annuity, when such action would operate to the overall detriment of the interests of the individual.

191—15.3(507B) Advertising.

15.3(1) *Form and content of advertisements.* The format and content of an advertisement shall be truthful and sufficiently complete and clear to avoid deception or the capacity or tendency to misrepresent or deceive. Whether an advertisement has a capacity or tendency to misrepresent or deceive shall be determined by the overall impression that the advertisement may be reasonably expected to create upon an individual in the segment of the public to which it is primarily directed and who has average education, intelligence and familiarity with insurance terminology for products in that market.

Information regarding exceptions, limitations, reductions and other restrictions required to be disclosed by this rule shall not be minimized, rendered obscure or presented in an ambiguous fashion or intermingled with the context of the advertisements so as to be confusing or misleading.

15.3(2) *Prohibited terms and disclosure requirements for health insurance.*

a. No advertisement shall contain or use words or phrases such as "all"; "full"; "complete"; "comprehensive"; "unlimited"; "up to"; "as high as"; "this policy will help fill some of the gaps that Medicare and your present insurance leave out"; "this policy will help to replace your income" (when used to express loss of time benefits); or similar words and phrases, in a manner which exaggerates any benefits beyond the terms of the policy.

b. No advertisement shall contain descriptions of a policy limitation, exception, or reduction, worded in a positive manner to imply that it is a benefit, such as describing a waiting period as a "benefit builder" or stating "even preexisting conditions are covered after two years." Words and phrases used in an advertisement to describe such policy limitations, exceptions and reductions shall fairly and accurately describe the negative features of such limitations, exceptions and reductions of the policy offered.

c. No advertisement of a benefit for which payment is conditional upon confinement in a hospital or similar facility shall use words or phrases such as "tax free," "extra cash" and substantially similar

phrases which have the capacity, tendency or effect of misleading the public into believing that the policy advertised will, in some way, enable an individual to make a profit from being hospitalized.

d. No advertisement shall use the words "only"; "just"; "merely"; "minimum" or similar words or phrases to describe the applicability of any exceptions and reductions, such as: "This policy is subject to the following minimum exceptions and reductions."

e. An advertisement which refers to either a dollar amount, or a period of time for which any benefit is payable, or the cost of the policy, or specific policy benefit, or the loss for which such benefit is payable, shall also disclose those exceptions, reductions, and limitations affecting the basic provisions of the policy without which the advertisement would have the capacity or tendency to mislead or deceive.

f. An advertisement may contain a brief description of coverage in an invitation to inquire so long as it is limited to a brief description of the loss for which benefits are payable. The brief description may also contain the dollar amount of benefits payable or the period of time during which benefits are payable, or both, but may not refer to the cost of the policy.

g. An advertisement for a policy which contains a waiting, elimination, probationary, or similar time period between the effective date of the policy and the effective date of coverage under the policy or a time period between the date a loss occurs and the date benefits begin to accrue for such loss shall prominently disclose the existence of such periods.

h. An invitation to inquire shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reduction of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance agent or the company [whichever is applicable]."

15.3(3) *Prohibited terms in life insurance and annuity policies.* No advertisement for a life insurance or annuity policy shall use the terms "investment," "investment plan," "founder's plan," "charter plan," "expansion plan," "profit," "profits," "profit sharing," "interest plan," "savings," "savings plan," "retirement plan," or other similar term which has the capacity or tendency to mislead an insured or prospective insured to believe that the insurer is offering something other than an insurance policy or some benefit not available to other individuals of the same class and equal expectation of life. An advertisement shall not state that there are "no more premiums" or that premiums will "vanish" or "disappear" or use similar terms when such statement is not based on the guaranteed rates.

15.3(4) *Exclusions, limitations, exceptions and reductions.* Words and phrases used in an advertisement to describe policy exclusions, limitations, exceptions and reductions shall clearly, prominently and accurately indicate the negative or limited nature of the exclusions, limitations, exceptions and reductions.

An advertisement for a policy providing benefits for specified illnesses only, such as cancer, or other policies providing benefits that are limited in nature shall clearly and conspicuously in prominent type state the limited nature of the policy. The statement shall be worded in language identical to or substantially similar to the following: "THIS IS A LIMITED POLICY," "THIS POLICY PROVIDES LIMITED BENEFITS," or "THIS IS A CANCER-ONLY POLICY."

15.3(5) *Use of statistics.* An advertisement shall not contain statistical information relating to any insurer or policy unless it accurately reflects recent and relevant facts. The source of any such statistics used in an advertisement shall be identified therein.

15.3(6) *Introductory, initial or special offers.*

a. An advertisement shall not directly or by implication represent that a policy is an introductory, initial or special offer, or that a person will receive advantages not available at a later date, or that the offer is available only to a specified group of persons, unless such is the fact.

b. An advertisement shall not offer a policy which utilizes a reduced initial premium rate in a manner which overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium must be stated in each portion of the advertisement where the initial reduced premium appears. This paragraph shall not apply to annual renewable term policies.

15.3(7) *Testimonials or endorsements by third parties.*

a. Testimonials used in advertisements must be genuine, represent the current opinion of the author, be applicable to the policy advertised and be accurately reproduced. The insurer, in using a testimonial, makes as its own all of the statements contained therein, and the advertisement, including such statement, is subject to all the provisions of these rules.

b. If the person making a testimonial or an endorsement has a financial interest in the insurer or a related entity as a stockholder, director, officer, employee, or otherwise, such fact shall be disclosed in the advertisement. If a person is compensated for making a testimonial or endorsement, such fact shall be disclosed in the advertisement by language substantially as follows: "Paid Endorsement." This rule does not require disclosure of union "scale" wages required by union rules if the payment is actually for such "scale" for TV or radio performances. The payment of substantial amounts, directly or indirectly, for "travel and entertainment" for filming or recording of TV or radio advertisements constitutes compensation and requires disclosure. This rule does not apply to an institutional advertisement which has as its sole purpose the promotion of the insurer.

c. An advertisement which states or implies that an insurer or an insurance product has been approved or endorsed by any person or other organizations must also disclose any proprietary or other relationship between the parties.

15.3(8) *Disparaging and incomplete comparisons and statements.* An advertisement shall not directly or indirectly make unfair or incomplete comparisons of policies or benefits or comparisons of noncomparable policies of other insurers, and shall not disparage other insurers, their policies, services or business methods, and shall not disparage or unfairly minimize competing methods of marketing insurance. An advertisement shall not contain statements which are untrue in fact, or by implication misleading, with respect to the assets, corporate structure, financial standing, age or relative position of an insurer in the insurance business.

15.3(9) *Identity of insurer.*

a. The name of the actual insurer shall be clearly identified in all advertisements for a particular policy. An advertisement shall not use a trade name, insurance group designation, name of a parent company, name of a particular company division, service mark, slogan, symbol or other device which would have the capacity and tendency to misrepresent the true identity of an insurer.

b. No advertisement shall use any combination of words, symbols, or physical materials which by its content, phraseology, shape, color or other characteristics is so similar to combinations of words, symbols, or physical materials used by a municipal, state or federal agency that it would lead a reasonable individual to believe that the advertisement is approved, endorsed or accredited by an agency of the municipal, state, or federal government.

15.3(10) *Disclosure requirements for life insurance and annuities.*

a. An advertisement for a policy containing graded or modified benefits shall prominently display any limitation of benefits. If the premium is level and coverage decreases or increases with age or duration, such fact shall be prominently disclosed.

b. An advertisement for a policy with nonlevel premiums shall prominently describe the premium changes.

c. Dividends.

(1) An advertisement shall not state or imply that the payment or amount of dividends is guaranteed. If dividends for an annuity are illustrated, the illustration must be based on the insurer's illustrated scale and must contain a statement that the illustration is not to be construed as a guarantee or estimate of dividends to be paid in the future.

(2) An advertisement shall not state or imply that the illustrated scale under a participating policy or pure endowments will be or can be sufficient at any future time to ensure, without the further payment of premiums, the receipt of benefits, such as a paid-up policy, unless the advertisement clearly and precisely explains (1) what benefits or coverage would be provided at such time and (2) under what conditions this would occur.

d. An advertisement of a deferred annuity shall not state the net premium accumulation interest rate unless it discloses in close proximity thereto and with equal prominence the actual relationship between the gross and net premiums.

e. An advertisement that states the projected values of a policy must use the guaranteed interest rates in determining such projected values and, in addition, may show other projected values based on interest rates which comply with the illustrated scale. Any statements containing or based upon an interest rate higher than the guaranteed accumulation interest rates shall likewise set forth with equal prominence comparable statements containing or based upon the guaranteed accumulation interest rates. If the policy does not contain a provision for a guaranteed interest rate, any advertisement showing projected values must clearly state that the rates are not guaranteed. This subrule does not apply to an illustration or supplemental illustration subject to the provisions of the Life Illustrations Model Regulation, 191 IAC 14.

f. An advertisement or presentation which does not recognize the time value of money through the use of appropriate interest adjustments shall not be used for comparing the cost of two or more life insurance policies. Such advertisement may be used for the purpose of demonstrating the cash flow pattern of a policy if such advertisement is accompanied by a statement disclosing that the advertisement does not recognize that, because of interest, a dollar in the future may not have the same value as a dollar at the time of the presentation.

g. An advertisement of benefits shall not display guaranteed and nonguaranteed benefits as a single sum unless they are also shown separately in close proximity thereto.

h. A statement regarding the use of life insurance cost indexes shall include an explanation that the indexes are useful only for the comparison of the relative costs of two or more similar policies.

i. A life insurance cost index which reflects dividends or an equivalent level annual dividend shall be accompanied by a statement that it is based on the insurer's illustrated scale and is not guaranteed.

15.3(11) *Special offers.* Advertisements, applications, requests for additional information and similar materials are prohibited if they state or imply that the recipient has been individually selected to be offered insurance or has had the recipient's eligibility for the insurance individually determined in advance when the advertisement is directed to all individuals in a group or to all individuals whose names appear on a mailing list.

15.3(12) *Disclosure requirement.* In an advertisement that is an invitation to contract for an accident and sickness insurance policy that is guaranteed renewable, cancelable or renewable at the option of the company, the advertisement shall disclose that the insurer has the right to increase premium rates if the policy so provides.

15.3(13) *Group or quasi-group implications.*

a. An advertisement of a particular policy shall not state or imply that prospective insureds become group or quasi-group members covered under a group policy and, as members, enjoy special rates or underwriting privileges, unless that is the fact.

b. This rule prohibits the solicitation of a particular class, such as governmental employees, by use of advertisements which state or imply that their class membership entitles the member to reduced rates on a group or other basis when, in fact, the policy being advertised is sold only on an individual basis at regular rates.

c. Advertisements that indicate that a particular coverage or policy is exclusively for "preferred risks" or a particular segment of the population or that a particular segment of the population is an acceptable risk, when the distinctions are not maintained in the issuance of policies, are prohibited.

d. An advertisement to join an association, trust or discretionary group that is also an invitation to contract for insurance coverage shall clearly disclose that the applicant will be purchasing both membership in the association, trust or discretionary group and insurance coverage. The insurer shall solicit insurance coverage on a separate and distinct application that requires a separate signature. The separate and distinct application required need not be on a separate document or contained in a separate mailing. The insurance program shall be presented so as not to conceal the fact that the prospective members are purchasing insurance as well as applying for membership, if that is the case. Similarly,

the use of terms such as "enroll" or "join" to imply group or blanket insurance coverage is prohibited when that is not the fact.

e. Advertisements for group or franchise group plans that provide a common benefit or a common combination of benefits shall not imply that the insurance coverage is tailored or designed specifically for that group, unless that is the fact.

15.3(14) *Compliance with Medicare supplement advertising rules.* Insurers and producers shall comply with the Medicare supplement advertising rules set forth in 191—Chapter 37, Division II.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—15.4(507B) Life insurance cost and benefit disclosure requirements.

15.4(1) The definition of terms applicable to this rule and its appendices will be found in Appendix I.

15.4(2) Except as hereafter exempted, this rule shall apply to any solicitation, negotiation or procurement of life insurance occurring within this state. This rule shall apply to any insurer issuing life insurance contracts including fraternal benefit societies.

Unless otherwise specifically included, this rule shall not apply to:

a. Annuities.

b. Credit life insurance.

c. Group life insurance, except for disclosures relating to preneed funeral contracts or prearrangements as provided herein. These disclosure requirements shall extend to the issuance or delivery of certificates as well as to the master policy.

d. Life insurance policies issued in connection with pension and welfare plans as defined by and which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

e. Variable life insurance under which the death benefits and cash values vary in accordance with unit values of investments held in a separate account.

15.4(3) Prior to or at delivery of a life insurance policy, an insurer or producer shall provide the prospective purchaser the following:

a. A life insurance buyer's guide in the current form prescribed by the National Association of Insurance Commissioners or language approved by the commissioner of insurance, and

b. A policy summary as defined in Appendix I.

15.4(4) A policy summary is not required to include information available in the policy form or illustration. If an illustration subject to the provisions of 191 IAC 14, Life Insurance Illustrations Model Regulation, is used in the sale of a policy, delivery of a policy summary is not required. A policy summary may not include any element that is not guaranteed.

191—15.5(507B) Health insurance sales to individuals 65 years of age or older. The sale of duplicate Medicare supplement insurance is prohibited.

191—15.6(507B) Preneed funeral contracts or prearrangements.

15.6(1) *Advertising.* An advertisement for the solicitation or sale of a preneed funeral contract or prearrangement which is funded or to be funded by a life insurance policy or annuity contract shall adequately disclose the following:

a. The fact that a life insurance policy or annuity contract is involved or being used to fund a prearrangement, and

b. The nature of the relationship among the soliciting producer or producers, the provider of the funeral or cemetery merchandise or services, the administrator and any other person.

15.6(2) *Application.* Prior to accepting an application, initial premium or deposit, an insurer or producer must adequately disclose:

a. The relationship of the life insurance policy or annuity contract to the funding of the prearrangement and the nature and existence of any guarantees relating to the prearrangement;

b. The impact on the prearrangement of any:

(1) Changes in the life insurance policy or annuity contract including, but not limited to, changes in the assignment, beneficiary designation or use of the proceeds,

(2) Penalties to be incurred by the policyholder as a result of failure to make premium payments,

(3) Penalties to be incurred or moneys to be received as a result of cancellation or surrender of the life insurance policy or annuity contract;

c. A list of the merchandise and services which are supplied or contracted for in the prearrangement and all relevant information concerning the price of the funeral services, including an indication that the purchase price is either guaranteed at the time of purchase or to be determined at the time of need;

d. All relevant information concerning what occurs and whether any entitlements or obligations arise if there is a difference between the proceeds of the life insurance policy or annuity contract and the amount actually needed to fund the prearrangement;

e. Any penalties or restrictions including, but not limited to, geographic restrictions or the inability of the provider to perform, on the delivery of merchandise, services or the prearrangement guarantee; and

f. The fact that a sales commission or other form of compensation is being paid and, if so, the identity of the person to whom it is paid.

191—15.7(507B) Twisting prohibited. No insurer or producer shall engage in the act of twisting.

191—15.8(507B) Producer responsibilities.

15.8(1) *Required disclosures.* A producer shall inform the prospective purchaser, prior to commencing an insurance sales presentation, that the producer is acting as an insurance producer and inform the prospective purchaser of the producer's full name and the full name of the insurance company which the producer will represent in the insurance sales presentation. In sales situations in which a producer is not involved, the insurer shall identify its full name to a prospective purchaser.

15.8(2) *Improper sales tactics.*

a. Producers and insurers shall not employ any method of marketing or tactic which uses undue pressure, force, fright, threat, whether explicit or implied, to solicit the purchase of insurance.

b. A producer shall not:

(1) Execute a transaction for an insurance customer without authorization by the customer to do so; or

(2) Commit any act which shows that the producer has exerted undue influence over a person.

c. Producers and insurers shall not, without good cause:

(1) Fail or refuse to furnish any individual, upon reasonable request, information to which that individual is entitled, or to respond to a formal written request or complaint from any individual.

(2) Sell an insurance policy or rider to an individual which is a duplication of a policy or rider which the individual owns or for which the individual has applied at the time of the sale.

15.8(3) *Prohibited designations and fees.*

a. When an insurance producer is engaged only in the sale of insurance policies or annuities, the insurance producer shall not hold the producer out, directly or indirectly, to the public as a "financial planner," "investment adviser," "consultant," "financial counselor," or any other specialist solely engaged in the business of financial planning or giving advice relating to investments, insurance, real estate, tax matters or trust and estate matters. This provision does not preclude insurance producers who hold some form of formal recognized financial planning or consultant certification or designation from using this certification or designation when they are only selling insurance.

b. An insurance producer shall not engage in the business of financial planning without disclosing to the client prior to the execution of the agreement required by paragraph *"c"* or to the solicitation of the sale of a product or service that the producer is also an insurance producer and that a commission for the sale of an insurance product will be received in addition to a fee for financial planning, if such is the case. The disclosure requirement under this paragraph may be met by including the disclosure in any disclosure required by federal or state securities law.

c. An insurance producer shall not charge fees other than commissions unless such fees are based upon a written agreement signed by the client in advance of the performance of the services under the agreement. A copy of the agreement must be provided to the client at the time the agreement is signed by the client. The agreement must specifically state:

(1) The service for which the fee is to be charged;

(2) The amount of the fee to be charged or how it will be determined or calculated; and

(3) That the client is under no obligation to purchase any insurance product through the insurance producer or consultant.

The insurance producer shall retain a copy of the agreement for not less than three years after completion of services, and a copy shall be available to the commissioner upon request.

d. Producers shall not charge an additional fee for services that are customarily associated with the solicitation, negotiation or servicing of policies. This prohibition shall not apply to assigned risk policies and commercial property and casualty policies. Any additional fee that a producer intends to charge for assigned risk policies and commercial property and casualty policies must be fully disclosed to the insured.

e. Producers shall comply with rule 191—10.19(522B) in using senior-specific certifications and professional designations in the sale of life insurance and annuities.

15.8(4) *Suitability.* A producer shall not recommend to any person the purchase, sale or exchange of any life insurance policy, or any rider, endorsement or amendment thereto, without reasonable grounds to believe that the transaction or recommendation is not unsuitable for the person based upon reasonable inquiry concerning the person's insurance objectives, financial situation and needs, age and other relevant information known by the producer. For purposes of this subrule, when a producer recommends a group life insurance policy, "person" shall refer to the intended group policyowner.

15.8(5) *Prohibited acts.*

a. For purposes of this subrule:

"Gift" means a rendering of anything of value in return for which legal consideration of equal or greater value is not given and received.

"Immediate family" shall include parent, mother-in-law, father-in-law, spouse, former spouse, brother, sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, child and stepchild. In addition, "immediate family" shall include any other person who is supported, directly or indirectly, to a material extent by a producer.

"Loan" means an agreement to advance property, including but not limited to money, in return for the promise that payment will be made for use of the property.

b. A producer shall not:

(1) Solicit or accept, directly or indirectly, at any time, a personal loan from an insurance customer that in the aggregate exceeds $250, unless the customer is:

1. A bank, savings and loan, credit union or other recognized lending entity; or

2. A member of the producer's immediate family.

(2) Solicit or accept, directly or indirectly, at any time, a gift to the producer or to a member of the producer's immediate family from an insurance customer that in the aggregate exceeds $250, unless the customer is a member of the producer's immediate family. A gift to a member of the producer's immediate family shall be included in calculating the aggregate amount. A gift received by a member of the producer's immediate family from a customer that is not a member of the producer's immediate family in excess of the aggregate amount shall be deemed a violation of this subrule by the producer.

(3) Solicit or accept being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity of a customer, unless the customer is a member of the producer's immediate family.

(4) Evade or otherwise violate the spirit of this subrule by terminating a producer relationship with an insurance customer for the purpose of soliciting or accepting a loan or a gift, or for the purpose of being named as a beneficiary, executor or trustee in a will, trust, insurance policy or annuity that the producer otherwise would have been prohibited from soliciting or accepting by this subrule. A producer will not be in violation of this subrule if the producer has made a bona fide termination of the producer

relationship with the insurance customer and has conducted no insurance or other business with the insurance customer for a period of three years.

c. Transactions which involve nominal interim ownership immediately precedent to transfer of ownership into a trust are exempt from this subrule.

191—15.9(507B) Right to return a life insurance policy or annuity (free look). The owner of an individual policy has the right, within ten days after receipt of a life insurance policy or annuity, to a free-look period. During this period, the policyowner may return the life insurance policy or annuity to the insurer at its home office, branch office, or to the producer through whom it was purchased. If so returned, the premium paid will be promptly refunded, the policy or annuity voided and the parties returned to the same position as if a policy or annuity had not been issued. If the transaction involved a replacement, the length of the free-look period will be determined according to 191—Chapter 16.

If the transaction involved a variable product, the amount to be refunded shall be determined according to the policy language. The calculations must comply with the relevant rule in either 191—Chapter 16, Replacement of Life Insurance and Annuities, or 191—Chapter 33, Variable Life Insurance Model Regulation.

191—15.10(507B) Uninsured/underinsured automobile coverage—notice required.

15.10(1) *Contents of notice.* Automobile insurance policies delivered in this state shall include a notice which contains and is limited to the following language:

NOTICE REGARDING UNINSURED/UNDERINSURED COVERAGE

Uninsured/underinsured coverage does not cover damage done to your vehicle. It provides benefits only for bodily injury caused by an uninsured or underinsured motorist. If you wish to be insured for damage done to your vehicle, you must have collision coverage. Please check your policy to make sure you have the coverage desired.

15.10(2) *Form of notice.* Notice may be provided on a separate form or may be stamped on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the notice in this rule is required by the insurance division.

191—15.11(507B) Unfair discrimination.

15.11(1) *Sex discrimination.*

a. A contract shall not be denied to an individual based solely on that individual's sex or marital status. No benefits, terms, conditions or type of coverage shall be restricted, modified, excluded, or reduced on the basis of the sex or marital status of the insured or prospective insured except to the extent permitted under the Iowa Code or Iowa Administrative Code. An insurer may consider marital status for the purpose of defining individuals eligible for dependents' benefits. This subrule does not apply to group life insurance policies or group annuity contracts issued in connection with pension and welfare plans which are subject to the federal Employee Retirement Income Security Act of 1974 (ERISA).

b. Specific examples of practices prohibited by this subrule include, but are not limited to, the following:

(1) Denying coverage to individuals of one sex employed at home, employed part-time or employed by relatives when coverage is offered to individuals of the opposite sex similarly employed.

(2) Denying policy riders to persons of one sex when the riders are available to persons of the opposite sex.

(3) Denying a policy under which maternity coverage is available to an unmarried female when that same policy is available to a married female.

(4) Denying, under group contracts, dependent coverage to spouses of employees of one sex, when dependent coverage is available to spouses of employees of the opposite sex.

(5) Denying disability income coverage to employed members of one sex when coverage is offered to members of the opposite sex similarly employed.

(6) Treating complications of pregnancy differently from any other illness or sickness under the contract.

(7) Restricting, reducing, modifying, or excluding benefits relating to coverage involving the genital organs of only one sex.

(8) Offering lower maximum monthly benefits to members of one sex than to members of the opposite sex who are in the same underwriting and occupational classification under a disability income contract.

(9) Offering more restrictive benefit periods and more restrictive definitions of disability to members of one sex than to members of the opposite sex in the same underwriting and occupational classifications under a disability income contract.

(10) Establishing different contract conditions based on gender which limit the benefit options a policyholder may exercise.

(11) Limiting the amount of coverage due to an insured's or prospective insured's marital status unless such limitation applies only to coverage for dependents and is uniformly applied to males and females.

c. When rates are differentiated on the basis of sex, an insurer must, upon the request of the commissioner of insurance, justify the rate differential in writing to the satisfaction of the commissioner. All rates shall be based on sound actuarial principles or a valid classification system and actual experience statistics, if available.

d. This subrule shall not affect the right of fraternal benefit societies to determine eligibility requirements for membership. If a fraternal benefit society does, however, admit members of both sexes, this subrule is applicable to the insurance benefits available to its members.

15.11(2) *Physical or mental impairment.* No contract, benefits, terms, conditions or type of coverage shall be denied, restricted, modified, excluded or reduced solely on the basis of physical or mental impairment of the insured or prospective insured except where based on sound actuarial principles or related to actual or reasonably anticipated experience. For purposes of this subrule, both blindness and partial blindness shall be considered a physical impairment.

15.11(3) *Income discrimination.* An insurer shall not refuse to issue, limit the amount or apply different rates to individuals of the same class in the sale of individual life insurance based solely upon the prospective insured's legal source or level of income, unless such action is based on sound actuarial principles or is related to actual or reasonably anticipated experience. The portion of this subrule pertaining to level of income does not:

a. Apply to the sale of disability income insurance of any kind or of any insurance designed to protect against economic loss due to a disruption in the regular flow of an individual's earned income;

b. Prohibit the sale of any insurance or annuity which is made available only to employees;

c. Prohibit basing the amount of insurance sold to an employee on a multiple or a percentage of the employee's salary or prohibit limiting availability to employees who have achieved a certain employment status as defined by the employer;

d. Prohibit insurers from providing life or health insurance as an incidental benefit through a qualified pension plan;

e. Prohibit insurers from applying suitability standards which include income as a factor in the sale of any life insurance or annuity products;

f. Prohibit insurers from establishing maximum or minimum amounts of insurance that will be issued to individuals so long as this is pursuant to a preexisting specialized marketing strategy which the insurer can demonstrate is related to the financial capacity of the insurer to write business or to bona fide transaction costs.

15.11(4) *Domestic abuse.* A contract shall not be denied to an individual based solely on the fact that such individual has been or is believed to have been a victim of domestic abuse as defined in Iowa Code section 236.2.

15.11(5) *Genetic information.* Any action by an insurer that is not in compliance with Title I of the Genetic Information Nondiscrimination Act of 2008 (Public Law 110-233, 122 Stat. 881) shall be

considered an unfair trade practice and shall be subject to the penalties of Iowa Code chapter 507B and of these rules.
[**ARC 7796B**, IAB 5/20/09, effective 5/22/09; **ARC 7965B**, IAB 7/15/09, effective 8/19/09]

191—15.12(507B) Testing restrictions of insurance applications for the human immunodeficiency virus.

15.12(1) *Written release.* No insurer shall obtain a test of any individual in connection with an application for insurance for the presence of an antibody to the human immunodeficiency virus unless the individual to be tested provides a written release on a form which contains the following information:

a. A statement of the purpose, content, use, and meaning of the test.

b. A statement regarding disclosure of the test results including information explaining the effect of releasing the information to an insurer.

c. A statement of the purpose for which test results may be used.

15.12(2) *Form.* A preapproved form is provided in Appendix II. An insurer wishing to utilize a form which deviates from the language in the appendix to these rules shall submit the form to the insurance division for approval. Any form containing, but not limited to, the language in the appendix shall be deemed approved.

15.12(3) *Test results.* A person engaged in the business of insurance who receives results of a positive human immunodeficiency virus (HIV) test in connection with an application for insurance shall report those results to a physician or alternative testing site of the applicant's or policyholder's choice or, if the applicant or policyholder does not choose a physician or alternative testing site to receive the results, to the Iowa department of public health.

191—15.13(507B) Records maintenance.

15.13(1) *Complaint and business records.*

a. An insurer shall maintain its books, records, documents and other business records in such an order that data regarding complaints, claims, rating, underwriting and marketing are accessible and retrievable for examination by the insurance commissioner.

b. An insurer shall maintain a complete record of all the complaints received since the date of its last examination by the insurer's state of domicile or port-of-entry state. This record shall indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition of each complaint, and the time it took to process each complaint. Appendix IV sets forth the minimum information required to be contained in the complaint record.

15.13(2) *Insurer's control over advertisements.* Every insurer shall establish and at all times maintain a system of control over the content, form, and method of dissemination of all advertisements which explain a particular policy. All such advertisements, whether written, created, designed or presented by the insurer or its appointed producer, shall be the responsibility of the insurer whose particular policies are so advertised. As part of this requirement, each insurer shall maintain at its home or principal office a complete file containing a specimen copy of every printed, published or prepared advertisement of its policies, with a notation indicating the manner and extent of distribution and the form number of any policy advertised. Such file shall be subject to inspection by the insurance division. All such advertisements shall be maintained for a period of either four years or until the filing of the next regular report on examination of the insurer, whichever is the longer period of time.

15.13(3) *Education and training materials.* Every insurer shall establish and maintain a system of control over the content and form of all material used by the insurer or any of its employees for the recruitment, training, and education of producers in the sale of insurance. Upon request, copies of these materials shall be made available to the commissioner.

191—15.14(505,507B) Enforcement section—cease and desist and penalty orders.

15.14(1) If, after hearing, the commissioner determines that a person has engaged in an unfair trade practice in violation of these rules, an unfair method of competition, or an unfair or deceptive act or practice in violation of Iowa Code chapter 507B, the commissioner shall reduce the findings to writing

and shall issue and cause to be served upon the person charged with the violation a copy of such findings and an order requiring the person to cease and desist from engaging in such method of competition, act or practice. The commissioner also may order one or more of the following:

a. Payment of a civil penalty of not more than $1,000 for each act or violation, but not to exceed an aggregate penalty of $10,000, unless the person knew or reasonably should have known that the actions were in violation of these rules or of Iowa Code chapter 507B, in which case the penalty shall be not more than $5,000 for each act or violation, but not to exceed an aggregate penalty of $50,000 in any one six-month period. If the commissioner finds that a violation of these rules or of Iowa Code chapter 507B was directed, encouraged, condoned, ignored, or ratified by the employer of the person or by an insurer, the commissioner shall also assess a fine to the employer or insurer;

b. Suspension or revocation of an insurer's certificate of authority or the producer's license if the insurer or producer knew or reasonably should have known that it was in violation of these rules or of Iowa Code chapter 507B;

c. Payment of interest at the rate of 10 percent per annum if the commissioner finds that the insurer failed to pay interest as required under Iowa Code section 507B.4, subsection 12;

d. Full disclosure by the insurer of all terms and conditions of the policy to the policyowner;

e. Payment of the costs of the investigation and administrative expenses related to any act or violation. The commissioner may retain funds collected pursuant to any settlement, enforcement action, or other legal action authorized under federal or state law for the purpose of reimbursing costs and expenses of the division.

15.14(2) Any person who violates a cease and desist order of the commissioner while such order is in effect may, after notice and hearing and upon order of the commissioner, be subject at the discretion of the commissioner to one or both of the following:

a. A civil penalty of not more than $10,000 for each and every act or violation.

b. Suspension or revocation of such person's license.

191—15.15 to **15.30** Reserved.

DIVISION II
CLAIMS

191—15.31(507B) General claims settlement guidelines. No insurer shall issue checks or drafts in partial settlement of a loss or claim under a specific coverage that contains language purporting to release the insurer or its insured from total liability.

191—15.32(507B) Prompt payment of certain health claims. Effective July 1, 2002, the following provisions apply:

15.32(1) *Definitions and scope.*

a. For purposes of this rule, the following definitions apply:

"Circumstance requiring special treatment" means:

1. A claim that an insurer has a reasonable basis to suspect may be fraudulent or that fraud or a material misrepresentation may have occurred under the benefit certificate or policy or in obtaining such certificate or policy; or

2. A matter beyond the insurer's control, such as an act of God, insurrection, strike or other similar labor dispute, fire or power outage or, for a group-sponsored health plan, the failure of the sponsoring group to pay premiums to the insurer in a timely manner; or

3. Similar unique or special circumstances which would reasonably prevent an insurer from paying an otherwise clean claim within 30 days.

"Clean claim" means clean claim as defined in 2001 Iowa Acts, chapter 69, section 8(2b).

"Coordination of benefits for third-party liability" means a claim for benefits by a covered individual who has coverage under more than one health benefit plan.

"Insurer" means insurer as defined in 2001 Iowa Acts, chapter 69, section 7.

"Properly completed billing instrument" means:

1. In the case of a health care provider that is not a health care professional:

- The Health Care Finance Administration (HCFA) Form 1450, also known as Form UB-92, or similar form adopted by its successor Centers for Medicare/Medicaid Services (CMS) as adopted by the National Uniform Billing Committee (NUBC) with data element usage prescribed in the UB-92 National Uniform Billing Data Elements Specification Manual, or
- The electronic format for institutional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; or

2. In the case of a health care provider that is a health care professional:

- The HCFA Form 1500 paper form or its successor as adopted by the National Uniform Claim Committee (NUCC) and further defined by the NUCC in its implementation guide; or
- The electronic format for professional claims adopted as a standard by the Secretary of Health and Human Services pursuant to Section 1173 of the Social Security Act; and

3. Any other information reasonably necessary for an insurer to process a claim for benefits under the benefit certificate or policy with the insured contract.

b. Scope. This subrule applies to claims submitted to an insurer as defined above on or after July 1, 2002, and is limited to policies issued, issued for delivery, or renewed in this state.

15.32(2) *Insurer duty to promptly pay claims and pay interest.*

a. Insurers subject to this subrule shall either accept and pay or deny a clean claim for health care benefits under a benefit certificate or policy issued by the insurer within 30 days after the insurer's receipt of such claim. A clean claim is considered to be paid on the date upon which a check, draft, or other valid negotiable instrument is written. Insurers shall implement procedures to ensure that these payments are promptly delivered.

b. Insurers or entities that administer or process claims on behalf of an insurer who fail to pay a clean claim within 30 days after the insurer's receipt of a properly completed billing instrument shall pay interest. Interest shall accrue at the rate of 10 percent per annum commencing on the thirty-first day after the insurer's receipt of all information necessary to establish a clean claim. Interest will be paid to the claimant or provider based upon who is entitled to the benefit payment.

c. Insurers shall have 30 days from the receipt of a claim to request additional information to establish a clean claim. An insurer shall provide a written or electronic notice to the claimant or health care provider if additional information is needed to establish a clean claim. The notice shall include a full explanation of the information necessary to establish a clean claim.

d. Effective January 1, 2003, when a claim involves coordination of benefits, an insurer is required to comply with the requirements of this subrule when that insurer's liability has been determined.

15.32(3) *Certain insurance products exempt.* Claims paid under the following insurance products are exempt from the provisions of this subrule: liability insurance, workers' compensation or similar insurance, automobile or homeowners insurance, medical payment insurance, disability income insurance, or long-term care insurance.

This rule is intended to implement 2001 Iowa Acts, chapter 69, section 8, and Iowa Code section 507B.4 as amended by 2001 Iowa Acts, chapter 69.

191—15.33(507B) Audit procedures for medical claims.

15.33(1) *Prohibitions.* This rule applies to all claims paid on or after January 1, 2002:

a. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim more than two years after the submission of the claim to the insurer. Nothing in this rule prohibits an insurer from requesting all records associated with the claim.

b. Absent a reasonable basis to suspect fraud, an insurer may not audit a claim with a billed charge of less than $25.

15.33(2) *Standards.*

a. In auditing a claim, the insurer must make a reasonable effort to ensure that the audit is performed by a person or persons with appropriate qualifications for the type of audit being performed.

b. In auditing a claim, the auditor must use the coding guidelines and instructions that were in effect on the date the medical service was provided.

15.33(3) *Contents of audit request.* All correspondence regarding the audit of a claim must include the following information:

a. The name, address, telephone number and contact person of the insurer conducting the audit,

b. The name of the entity performing the audit if not the insurer,

c. The purpose of the audit, and

d. If included in the audit, the specific coding or billing procedure that is under review.

This rule is intended to implement Iowa Code section 507B.4, subsection 9, as amended by 2001 Iowa Acts, chapter 69.

191—15.34 to **15.40** Reserved.

191—15.41(507B) Claims settlement guidelines for property and casualty insurance. For purposes of this rule, "insurer" means property and casualty insurers.

15.41(1) An insurer shall fully disclose to first-party claimants all pertinent benefits, coverages or other provisions of a policy or contract under which a claim is presented.

15.41(2) Within 30 days after receipt by the insurer of properly executed proofs of loss, the first-party property claimant shall be advised of the acceptance or denial of the claim by the insurer. No insurer shall deny a claim on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given to the claimant in writing, and the claim file of the insurer shall contain documentation of the denial.

When there is a reasonable basis supported by specific information available for review by the commissioner that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(3) If the insurer needs more time to determine whether a first-party claim should be accepted or denied, the insurer shall so notify the first-party claimant within 30 days after receipt of the proof of loss and give the reasons more time is needed. If the investigation remains incomplete, the insurer shall, 45 days from the initial notification and every 45 days thereafter, send to the claimant a letter setting forth the reasons additional time is needed for investigation.

When there is a reasonable basis supported by specific information available for review by the commissioner for suspecting that the first-party claimant has fraudulently caused or contributed to the loss, the insurer is relieved from the requirements of this subrule. However, the claimant shall be advised of the acceptance or denial of the claim by the insurer within a reasonable time for full investigation after receipt by the insurer of a properly executed proof of loss.

15.41(4) Insurers shall not fail to settle first-party claims on the basis that responsibility for payment should be assumed by others except as may otherwise be provided by policy provisions.

15.41(5) No insurer shall make statements indicating that the rights of a third-party claimant may be impaired if a form or release, other than a release to obtain medical records, is not completed within a given period of time unless the statement is given for the purpose of notifying the third-party claimant of the provision of a statute of limitations.

15.41(6) The insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within 30 days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved, payments which are not in dispute under one of the coverages and where the payee is known should be tendered within 30 days if such payment would terminate the insurer's known liability under that coverage.

15.41(7) No producer shall conceal from a first-party claimant benefits, coverages or other provisions of any insurance policy or insurance contract when such benefits, coverages or other provisions are pertinent to a claim.

15.41(8) A claim shall not be denied on the basis of failure to exhibit property unless there is documentation of breach of the policy provisions to exhibit or cooperate in the claim investigation.

15.41(9) No insurer shall deny a claim based upon the failure of a first-party claimant to give written notice of loss within a specified time limit unless the written notice is a written policy condition. An insurer may deny a claim if the claimant's failure to give written notice after being requested to do so is so unreasonable as to constitute a breach of the claimant's duty to cooperate with the insurer.

15.41(10) No insurer shall indicate to a first-party claimant on a payment draft, check or in any accompanying letter that said payment is "final" or "a release" of any claim unless the policy limit has been paid or there has been a compromise settlement agreed to by the first-party claimant and the insurer as to coverage and amount payable under the contract.

15.41(11) No insurer shall request or require any insured to submit to a polygraph examination unless authorized under the applicable insurance contracts and state law.

191—15.42(507B) Acknowledgment of communications by property and casualty insurers. For purposes of this rule, "insurer" means property and casualty insurers.

15.42(1) Upon receiving notification of a claim, an insurer shall, within 15 days, acknowledge the receipt of such notice unless payment is made within that period of time. If an acknowledgment is made by means other than in writing, an appropriate notation of the acknowledgment shall be made in the claim file of the insurer and dated.

15.42(2) Upon receipt of any inquiry from the Iowa insurance division regarding a claim, an insurer shall, within 21 days of receipt of such inquiry, furnish the division with an adequate response to the inquiry, in duplicate.

15.42(3) The insurer shall reply within 15 days to all pertinent communications from a claimant which reasonably suggest that a response is expected.

15.42(4) Upon receiving notification of claim, an insurer shall promptly provide necessary claim forms, instructions and reasonable assistance so that first-party claimants can comply with the policy conditions and the insurer's reasonable requirements. Compliance with this subrule within 15 days of notification of a claim shall constitute compliance with subrule 15.42(1).

191—15.43(507B) Standards for settlement of automobile insurance claims.

15.43(1) Loss calculation and deviation guidelines.

a. Loss calculation. When the insurance policy provides for the adjustment and settlement of first-party automobile total losses on the basis of actual cash value or replacement with another automobile of like kind and quality, one of the following methods shall apply:

(1) The insurer may elect to offer a replacement automobile that is at least comparable in that it will be by the same manufacturer, same or newer year, similar body style, similar options and mileage as the insured vehicle and in as good or better overall condition and available for inspection at a licensed dealer within a reasonable distance of the insured's residence. All applicable taxes, license fees and other fees incident to the transfer of evidence of ownership of the automobile shall be paid by the insurer, at no cost to the insured, other than any deductible provided in the policy. The offer and any rejection thereof must be documented in the claim file.

(2) The insurer may elect a cash settlement based upon the actual cost, less any deductible provided in the policy, to purchase a comparable automobile including all applicable taxes, license fees and other fees incident to transfer of evidence of ownership of a comparable automobile. Such cost may be derived from:

1. The cost of two or more comparable automobiles in the local market area when comparable automobiles are available or were available within the last 90 days to consumers in the local market area; or

2. The cost of two or more comparable automobiles in areas proximate to the local market area, including the closest major metropolitan areas within or without the state, that are available or were available within the last 90 days to consumers when comparable automobiles are not available in the local market area; or

3. One of two or more quotations obtained by the insurer from two or more licensed dealers located within the local market area when the cost of comparable automobiles is not available; or

4. Any source for determining statistically valid fair market values that meet all of the following criteria:

- The source shall give primary consideration to the values of vehicles in the local market area and may consider data on vehicles outside the area.
- The source's database shall produce values for at least 85 percent of all makes and models for the last 15 model years taking into account the values of all major options for such vehicles.
- The source shall produce fair market values based on current data available from the area surrounding the location where the insured vehicle was principally garaged or a necessary expansion of parameters (such as time and area) to ensure statistical validity.

(3) If the insurer is notified within 35 days of the receipt of the claim draft that the insured cannot purchase a comparable vehicle for such market value, the insured shall have a right of recourse. The insurer shall reopen its claim file and the following procedure(s) shall apply:

1. The insurer may locate a comparable vehicle by the same manufacturer, same or newer year, similar body style and similar options and price range for the insured for the market value determined by the insurer at the time of settlement. Any such vehicle must be available through a licensed dealer; or
2. The insurer shall either pay the insured the difference between the market value before applicable deductions and the cost of the comparable vehicle of like kind and quality which the insured has located, or negotiate and effect the purchase of this vehicle for the insured; or
3. The insurer may elect to offer a replacement in accordance with the provisions set forth in subrule 15.43(1); or
4. The insurer may conclude the loss settlement as provided for under the appraisal section of the insurance contract in force at the time of loss. This appraisal shall be considered as binding against both parties, but shall not preclude or waive any other rights either party has under the insurance contract or a common law.

The insurer is not required to take action under this subrule if its documentation to the insured at the time of settlement included written notification of the availability and location of a specified and comparable vehicle of the same manufacturer, same or newer year, similar body style and similar options in as good or better condition as the total-loss vehicle which could have been purchased for the market value determined by the insurer before applicable deductions. The documentation shall include the vehicle identification number.

b. Deviation. When a first-party automobile total loss is settled on a basis which deviates from the methods described in paragraph *"a,"* the deviation must be supported by documentation giving particulars of the automobile's condition. Any deductions from such cost, including deduction for salvage, must be measurable, discernible, itemized and specified as to dollar amount and shall be appropriate in amount. The basis for such settlement shall be fully explained to the first-party claimant.

15.43(2) Where liability and damages are reasonably clear, an insurer shall not recommend that third-party claimants make claims under their own policies solely to avoid paying claims under the insurer's policy.

15.43(3) The insurer shall not require a claimant to travel an unreasonable distance either to inspect a replacement automobile, to obtain a repair estimate or to have the automobile repaired at a specific repair shop.

15.43(4) The insurer shall, upon the claimant's request, include the first-party claimant's deductible, if any, in subrogation demands. Subrogation recoveries shall be shared on a proportionate basis with the first-party claimant, unless the deductible amount has been otherwise recovered. No deduction for expenses shall be made from the deductible recovery unless an outside attorney is retained to collect such recovery. The deduction may then be for only a pro-rata share of the allocated loss adjustment expense.

15.43(5) Vehicle repairs. If partial losses are settled on the basis of a written estimate prepared by or for the insurer, the insurer shall supply the insured a copy of the estimate upon which the settlement is based. The estimate prepared by or for the insurer shall be reasonable, in accordance with applicable policy provisions, and of an amount which will allow for repairs to be made in a workmanlike manner. If the insured subsequently claims, based upon a written estimate which the insured obtains, that necessary repairs will exceed the written estimate prepared by or for the insurer, the insurer shall (1) pay the

difference between the written estimate and a higher estimate obtained by the insured, or (2) promptly provide the insured with the name of at least one repair shop that will make the repairs for the amount of the written estimate. If the insurer designates only one or two such repair shops, the insurer shall ensure that the repairs are performed according to automobile industry standards. The insurer shall maintain documentation of all such communications.

15.43(6) When the amount claimed is reduced because of betterment or depreciation, all information for such reduction shall be contained in the claim file. Such deductions shall be itemized and specified as to dollar amount and shall be appropriate for the amount of deductions.

15.43(7) When the insurer elects to repair an automobile, the insurer shall cause the damaged automobile to be restored to its condition prior to the loss at no additional cost to the claimant other than as stated in the policy, within a reasonable period of time.

15.43(8) Storage and towing. The insurer shall provide reasonable notice to an insured prior to termination of payment for automobile storage charges. The insurer shall provide reasonable time for the insured to remove the vehicle from storage prior to the termination of payment. Unless the insurer has provided an insured with the name of a specific towing company prior to the insured's use of another towing company, the insurer shall pay all reasonable towing charges.

15.43(9) Betterment. Betterment deductions are allowable only if the deductions reflect a measurable decrease in market value attributable to the poorer condition of, or prior damage to, the vehicle. Betterment deductions must be measurable, itemized, specified as to dollar amount and documented in the claim file.

15.43(10) Diminished value. Rescinded IAB 4/28/04, effective 4/7/04.

191—15.44(507B) Standards for determining replacement cost and actual cost values.

15.44(1) *Replacement cost.* When the policy provides for the adjustment and settlement of first-party losses based on replacement cost, the following shall apply:

a. When a loss requires repair or replacement of an item or part, any consequential physical damage incurred in making such repair or replacement not otherwise excluded by the policy shall be included in the loss. The insured shall not have to pay for betterment or any other cost except for the applicable deductible.

b. When a loss requires replacement of items and the replaced items do not match in quality, color or size, the insurer shall replace as much of the item as is necessary to result in a reasonably uniform appearance within the same line of sight. This subrule applies to interior and exterior losses. Exceptions may be made on a case-by-case basis. The insured shall not bear any cost over the applicable deductible, if any.

15.44(2) *Actual cash value.*

a. When the insurance policy provides for the adjustment and settlement of losses on an actual cash value basis on residential fire and extended coverage, the insurer shall determine the actual cash value. "Actual cash value" means replacement cost of property at time of loss, less depreciation, if any. Alternatively, an insurer may use market value in determining actual cash value. Upon the insured's request, the insurer shall provide a copy of the claim file worksheet(s) detailing any and all deductions for depreciation.

b. In cases in which the insured's interest is limited because the property has nominal or no economic value, or a value disproportionate to replacement cost less depreciation, the determination of actual cash value as set forth above is not required. In such cases, the insurer shall provide, upon the insured's request, a written explanation of the basis for limiting the amount of recovery along with the amount payable under the policy.

15.44(3) *Applicability.* This rule does not apply to automobile insurance claims.

191—15.45(507B) Guidelines for use of aftermarket crash parts in motor vehicles.

15.45(1) *Identification.* All aftermarket crash parts supplied for use in this state shall comply with the identification requirements of Iowa Code section 537B.4.

15.45(2) *Like kind and quality.* An insurer shall not require the use of aftermarket crash parts in the repair of an automobile unless the aftermarket crash part is certified by a nationally recognized entity to be at least equal in kind and quality to the original equipment manufacturer part in terms of fit, quality and performance, or that the part complies with federal safety standards.

15.45(3) *Contents of notice.* Any automobile insurance policy delivered in this state that pays benefits based on the cost of aftermarket crash parts or that requires the insured to pay the difference between the cost of original equipment manufacturer parts and the cost of aftermarket crash parts shall include a notice which contains and is limited to the following language:

NOTICE—PAYMENT FOR AFTERMARKET CRASH PARTS

Physical damage coverage under this policy includes payment for aftermarket crash parts. If you repair the vehicle using more expensive original equipment manufacturer (OEM) parts, you may pay the difference. Any warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle.

15.45(4) *Form of notice.* Notice may be provided on a separate form or may be printed prominently on the declaration page of the policy. The notice shall be provided in conjunction with all new policies issued. Notice may be provided at the time of application, but shall in no case be provided later than the time of delivery of the new policy. Insurers may inform applicants that the insurance division requires the notice in this rule.

191—15.46 to **15.50** Reserved.

DIVISION III
DISCLOSURE FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

191—15.51(507B) Purpose. The purpose of these rules is to ensure the provision of meaningful information to the purchasers of small face amount life insurance policies. The rules in this division apply to all small face amount policies not exempted under rule 15.53(507B) that are issued on or after July 1, 2004.

191—15.52(507B) Definition. *"Small face amount policy"* means a life insurance policy or certificate with an initial face amount of $15,000 or less.

191—15.53(507B) Exemptions. These rules apply to all group and individual life insurance policies and certificates except:

1. Variable life insurance;
2. Individual and group annuity contracts;
3. Credit life insurance;
4. Group or individual policies of life insurance issued to members of an employer group or other permitted group when:
   - Every plan of coverage was selected by the employer or other group representative;
   - Some portion of the premium is paid by the group or through payroll deduction; and
   - Group underwriting or simplified underwriting is used; and
5. Policies and certificates where an illustration has been provided pursuant to the requirements of 191—Chapter 14

191—15.54(507B) Disclosure requirements.

15.54(1) An insurer issuing a small face amount policy shall provide the disclosure included in Appendix IV if at any point in time over the term of the policy the cumulative premiums paid may exceed the face amount of the policy at that point in time. The required disclosure shall be provided to the policy owner or certificate holder no later than at the time the policy or certificate is delivered. The disclosure shall not be attached to the policy, but may be delivered with the policy.

15.54(2) If, for a particular policy form, the cumulative premiums may exceed the face amount for some demographic or benefit combination but not for all combinations, the insurer may choose to either:

a. Provide the disclosure only in those circumstances when the premiums may exceed the face amount; or

b. Provide the disclosure for all demographic and benefit combinations.

15.54(3) Cumulative premiums shall include premiums paid for riders. However, the face amount shall not include the benefit attributable to the riders.

191—15.55(507B) Insurer duties. The insurer and its producers shall have a duty to provide information to policyholders or certificate holders that ask questions about the disclosure statement.

191—15.56 to **15.60** Reserved.

DIVISION IV
ANNUITY DISCLOSURE REQUIREMENTS

191—15.61(507B) Purpose. The purpose of these rules is to provide standards for the disclosure of certain minimum information about annuity contracts to protect consumers and to foster consumer education. The rules specify the minimum information which must be disclosed and the method for disclosing it in connection with the sale of annuity contracts. The goal of these rules is to ensure that purchasers of annuity contracts understand certain basic features of annuity contracts. The rules in this division apply to all annuities not exempted under rule 15.62(507B) that are issued on or after July 1, 2004.

191—15.62(507B) Applicability and scope. These rules apply to all group and individual annuity contracts and certificates except:

15.62(1) Registered or nonregistered variable annuities or other registered products;

15.62(2) Immediate and deferred annuities that contain no nonguaranteed elements;

15.62(3) Annuities used to fund:

a. An employee pension plan which is covered by the Employee Retirement Income Security Act (ERISA);

b. A plan described by Section 401(a), 401(k) or 403(b) of the Internal Revenue Code, where the plan, for purposes of ERISA, is established or maintained by an employer;

c. A governmental or church plan defined in Section 414 of the Internal Revenue Code or a deferred compensation plan of a state or local government or a tax exempt organization under Section 457 of the Internal Revenue Code; or

d. A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor.

This subrule shall apply to annuities used to fund a plan or arrangement that is funded solely by contributions an employee elects to make whether on a pretax or after-tax basis, and where the insurance company has been notified that plan participants may choose from among two or more fixed annuity providers and there is a direct solicitation of an individual employee by a producer for the purchase of an annuity contract. As used in this subrule, direct solicitation shall not include any meeting held by a producer solely for the purpose of educating or enrolling employees in the plan or arrangement;

15.62(4) Structured settlement annuities; and

15.62(5) Charitable gift annuities as defined in Iowa Code chapter 508F.

191—15.63(507B) Definitions. For purposes of these rules:

"Contract owner" means the owner named in the annuity contract or the certificate holder in the case of a group annuity contract.

"Determinable elements" means elements that are derived from processes or methods that are guaranteed at issue and not subject to company discretion, but where the values or amounts cannot be determined until some point after the contract is issued. These elements include the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements. These elements may be described as guaranteed but

not determined at issue. An element is considered determinable if it was calculated from underlying determinable elements only, or from both determinable and guaranteed elements.

"Generic name" means a short title descriptive of the annuity contract for which application is made or an illustration is prepared, such as "single premium deferred annuity."

"Guaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges, or elements of formulas used to determine any of these elements, that are guaranteed and determined at issue. An element is considered guaranteed if all of the underlying elements that go into its calculation are guaranteed.

"Nonguaranteed elements" means the premiums, credited interest rates (including any bonus), benefits, values, non-interest-based credits, charges or elements of formulas used to determine any of these elements, that are subject to company discretion and are not guaranteed at issue. An element is considered nonguaranteed if any of the underlying nonguaranteed elements are used in its calculation.

"Structured settlement annuity" means a "qualified funding asset" as defined in Section 130(d) of the Internal Revenue Code or an annuity that would be a qualified funding asset under Section 130(d) but for the fact that it is not owned by an assignee under a qualified assignment.

191—15.64(507B) Standards for delivery of disclosure document and Buyer's Guide.

15.64(1) Delivery requirement. When an insurer or an insurance producer receives an application for an annuity contract, the insurer or insurance producer shall provide the applicant the disclosure document described in rule 191—15.65(507B) and the Buyer's Guide to Fixed Deferred Annuities, hereafter "the Buyer's Guide," in the current form prescribed by the National Association of Insurance Commissioners or in language approved by the commissioner of insurance.

15.64(2) Delivery methods. The documents required under this rule may be delivered as follows:

a. When an application for an annuity contract is taken in a face-to-face meeting with an insurance producer, the insurance producer shall provide the disclosure document and the Buyer's Guide at or before the time of application.

b. When an application for an annuity contract is taken by means other than a face-to-face meeting, the insurer shall send the applicant both the disclosure document and the Buyer's Guide no later than five business days after the completed application is received by the insurer.

c. When an application is received as a result of direct solicitation through the mail, the insurer may provide the Buyer's Guide and the disclosure document in the mailing which invites prospective applicants to apply for an annuity contract.

d. When an application is received via the Internet, the insurer may comply with this rule by taking reasonable steps to make the Buyer's Guide and disclosure document available for viewing and printing on the insurer's Web site.

15.64(3) A solicitation for an annuity contract which occurs other than in a face-to-face meeting shall include a statement that the proposed applicant may contact the Iowa insurance division for a free annuity Buyer's Guide. In lieu of the foregoing statement, an insurer may include a statement that the prospective applicant may contact the insurer for a free annuity Buyer's Guide.

15.64(4) When the Buyer's Guide and disclosure document are not provided at or before the time of application, a free-look period of no less than 15 days shall be provided for the applicant to return the annuity contract without penalty. This free look shall run concurrently with any other free look provided under the state law or rule.

191—15.65(507B) Content of disclosure documents. Insurers shall define terms used in the disclosure statement in language that facilitates understanding by a typical individual within the segment of the public to which the disclosure statement is directed. At a minimum, the following information shall be included in the disclosure document:

15.65(1) The generic name of the contract, the company product name, if different, and form number and the fact that it is an annuity;

15.65(2) The insurer's name and address;

15.65(3) A description of the contract and its benefits, emphasizing its long-term nature, including examples where appropriate, including but not limited to:

a. The guaranteed, nonguaranteed and determinable elements of the contract, and the limitations of those elements, if any, and an explanation of how the elements and limitations operate;

b. An explanation of the initial crediting rate, specifying any bonus or introductory portion, the duration of the rate and the fact that rates may change from time to time and are not guaranteed;

c. Periodic income options both on a guaranteed and nonguaranteed basis;

d. Any value reductions caused by withdrawals from or surrender of the contract;

e. How values in the contract can be accessed;

f. The death benefit, if available, and how it will be calculated;

g. A summary of the federal tax status of the contract and any penalties applicable on withdrawal of values from the contract; and

h. Impact of any rider, such as a long-term care rider;

15.65(4) Specific dollar amount or percentage charges and fees, listed with an explanation of how they apply; and

15.65(5) Information about the current guaranteed rate for new contracts that contains a clear notice that the rate is subject to change.

191—15.66(507B) Report to contract owners. For annuities in the payout period with changes in nonguaranteed elements and for the accumulation period of a deferred annuity, the insurer shall provide each contract owner with a report, at least annually, on the status of the contract that contains at least the following information:

1. The beginning and ending date of the current report period;
2. The accumulation and cash surrender value, if any, at the end of the previous report period and at the end of the current report period;
3. The total amounts, if any, that have been credited, charged to the contract value or paid during the current report period; and
4. The amount of outstanding loans, if any, as of the end of the current report period.

191—15.67(507B) Severability. If any provision of these rules or their application to any person or circumstance is for any reason held to be invalid by any court of law, the remainder of the rule and its application to other persons or circumstances shall not be affected.

DIVISION V
SUITABILITY IN ANNUITY TRANSACTIONS

191—15.68(507B) Purpose. The purpose of these rules is to set forth standards and procedures for recommendations to consumers that result in transactions involving annuity products so that the insurance needs and financial objectives of consumers at the times of the transactions are appropriately addressed. The rules in this division apply to all annuities not exempted under rule 15.69(507B) that are issued on or after January 1, 2007.

191—15.69(507B) Applicability and scope.

15.69(1) These rules shall apply to any recommendation to purchase or exchange an annuity made to a consumer by an insurance producer, or by an insurer where no producer is involved, that results in the purchase or exchange recommended.

15.69(2) Unless otherwise specifically included, this rule shall not apply to recommendations involving:

a. Direct-response solicitations where there is no recommendation based on information collected from the consumer.

b. Contracts used to fund the following:

(1) An employee pension or welfare benefit plan that is covered by the Employee Retirement and Income Security Act (ERISA);

(2) A plan described by Section 401(a), 401(k), 403(b), 408(k) or 408(p) of the Internal Revenue Code (IRC) if established or maintained by an employer;

(3) A government or church plan defined in Section 414 of the IRC, a government or church welfare benefit plan, or a deferred compensation plan of a state or local government or tax-exempt organization under Section 457 of the IRC;

(4) A nonqualified deferred compensation arrangement established or maintained by an employer or plan sponsor;

(5) Settlements or assumptions of liabilities associated with personal injury litigation or any dispute or claim resolution process; or

(6) Formal prepaid funeral contracts.

191—15.70(507B) Definitions. For purposes of this division:

"Annuity" means a fixed annuity or variable annuity that is individually solicited, whether the product is classified as an individual or group annuity.

"Insurance producer" means a person required to be licensed under the laws of this state to sell, solicit or negotiate insurance, including annuities.

"Insurer" means a company required to be licensed under the laws of this state to provide insurance products, including annuities.

"Recommendation" means advice provided by an insurance producer, or an insurer where no producer is involved, to an individual consumer that results in a purchase or exchange of an annuity in accordance with that advice.

191—15.71(507B) Duties of insurers and of insurance producers.

15.71(1) In recommending to a consumer the purchase of an annuity or the exchange of an annuity that results in another insurance transaction or series of insurance transactions, the insurance producer, or the insurer where no producer is involved, shall have reasonable grounds for believing that the recommendation is suitable for the consumer on the basis of the facts disclosed by the consumer as to the consumer's investments and other insurance products and as to the consumer's financial situation and needs.

15.71(2) Prior to the execution of a purchase or exchange of an annuity resulting from a recommendation, an insurance producer, or an insurer where no producer is involved, shall make reasonable efforts to obtain information concerning:

a. The consumer's financial status;

b. The consumer's tax status;

c. The consumer's investment objectives; and

d. Such other information used or considered to be reasonable by the insurance producer, or the insurer where no producer is involved, in making recommendations to the consumer.

15.71(3) An insurer or insurance producer's recommendation shall be reasonable under all the circumstances actually known to the insurer or insurance producer at the time of the recommendation. However, neither an insurance producer, nor an insurer where no producer is involved, shall have any obligation to a consumer under subrule 15.71(1) related to any recommendation if a consumer:

a. Refuses to provide relevant information requested by the insurer or insurance producer;

b. Decides to enter into an insurance transaction that is not based on a recommendation of the insurer or insurance producer; or

c. Fails to provide complete or accurate information.

15.71(4) Establishment and maintenance of a system of supervision.

a. An insurer either shall assure that a system to supervise recommendations that is reasonably designed to achieve compliance with this rule is established and maintained by complying with 15.71(4)*"c"* to *"e"* or shall establish and maintain such a system including, but not limited to:

(1) Maintaining written procedures; and

(2) Conducting periodic reviews of its records that are reasonably designed to assist in detecting and preventing violations of this rule.

b. A general agent and independent agency either shall adopt a system established by an insurer to supervise recommendations of its insurance producers that is reasonably designed to achieve compliance with this rule, or shall establish and maintain such a system including, but not limited to:

(1) Maintaining written procedures; and

(2) Conducting periodic reviews of records that are reasonably designed to assist in detecting and preventing violations of this rule.

c. An insurer may contract with a third party, including a general agent or independent agency, to establish and maintain a system of supervision as required by 15.71(4)*"a"* with respect to insurance producers under contract with or employed by the third party.

d. An insurer shall make reasonable inquiry to assure that the third party contracting under 15.71(4)*"c"* is performing the functions required under 15.71(4)*"a"* and shall take such action as is reasonable under the circumstances to enforce the contractual obligation to perform the functions. An insurer may comply with its obligation to make reasonable inquiry by doing all of the following:

(1) Annually obtain a certification from a third party senior manager who has responsibility for the delegated functions that the manager has a reasonable basis to represent, and does represent, that the third party is performing the required functions; and

(2) Based on reasonable selection criteria, periodically select third parties contracting under 15.71(4)*"c"* for a review to determine whether the third parties are performing the required functions. In conducting the review, the insurer shall perform those procedures that are reasonable under the circumstances.

e. An insurer that contracts with a third party pursuant to 15.71(4)*"c"* and that complies with the requirements to supervise in 15.71(4)*"d"* shall have fulfilled its responsibilities under 15.71(4)*"a."*

f. An insurer, general agent or independent agency is not required by 15.71(4)*"a"* or *"b"* to:

(1) Review, or provide for review of, all insurance producer solicited transactions; or

(2) Include in its system of supervision an insurance producer's recommendations to consumers of products other than the annuities offered by the insurer, general agent or independent agency.

g. A general agent or independent agency contracting with an insurer pursuant to 15.71(4)*"c"* shall promptly, when requested by the insurer pursuant to 15.71(4)*"d,"* give a certification as described in 15.71(4)*"d"* or give a clear statement that the general agent or independent agency is unable to meet the certification criteria.

h. No person may provide a certification under 15.71(4)*"d"*(1) unless:

(1) The person is a senior manager with responsibility for the delegated functions; and

(2) The person has a reasonable basis for making the certification.

15.71(5) Compliance with the National Association of Securities Dealers Conduct Rules pertaining to suitability shall satisfy the requirements under this rule for the recommendation of variable annuities. However, nothing in this subrule shall limit the insurance commissioner's ability to enforce the provisions of this rule.

191—15.72(507B) Mitigation of responsibility.

15.72(1) The commissioner may order:

a. An insurer to take reasonably appropriate corrective action for any consumer harmed by the insurer's, or by its insurance producer's, violation of the rules of this division;

b. An insurance producer to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of the rules of this division; and

c. A general agency or independent agency that employs or contracts with an insurance producer to sell or solicit the sale of annuities to consumers, to take reasonably appropriate corrective action for any consumer harmed by the insurance producer's violation of the rules of this division.

15.72(2) Any applicable penalty under Iowa Code chapter 507B for a violation of the rules in Division V of this chapter may be reduced or eliminated if corrective action for the consumer was taken promptly after a violation was discovered.

191—15.73(507B) Record keeping.

15.73(1) Insurers, general agents, independent agencies, and insurance producers shall maintain or be able to make available to the commissioner records of the information collected from the consumer and other information used in making the recommendations that were the basis for insurance transactions for ten years after the insurance transaction is completed by the insurer. An insurer is permitted, but shall not be required, to maintain documentation on behalf of an insurance producer.

15.73(2) Records required to be maintained by this rule may be maintained in paper, photographic, microprocess, magnetic, mechanical or electronic media or by any process that accurately reproduces the actual document.

191—15.74 to **15.79** Reserved.

DIVISION VI
INDEXED PRODUCTS TRAINING REQUIREMENT

191—15.80(507B,522B) Purpose. The purpose of the rules in this division is to require certain specific minimum training for insurance producers who wish to sell indexed annuities or indexed life insurance in Iowa. This additional training is necessary due to the complex nature of these indexed products and to ensure that insurance producers are able to determine whether an indexed product is suitable for a consumer and are able to adequately explain to a consumer how the indexed product works. The ultimate goal of these rules is to ensure that purchasers of indexed products understand basic features of the indexed products. The rules in this division apply to all indexed products sold on or after January 1, 2008.

191—15.81(507B,522B) Definitions. For the purpose of this division:

"CE credit" means one continuing education "credit" as defined in 191—Chapter 11.

"CE provider" means any individual or entity that is approved to offer continuing education courses in Iowa pursuant to 191—Chapter 11.

"Indexed products" means all fixed indexed life insurance and fixed indexed annuity products.

"Insurer" means an insurance company admitted to do business in Iowa which sells indexed products in Iowa.

"Producer" means a person required to obtain an insurance license under Iowa Code chapter 522B.

191—15.82(507B,522B) Special training required. A producer who wishes to sell indexed products in Iowa shall complete at least one four-credit indexed products training course, as described in this division, prior to providing any advice or making any sales presentation concerning an indexed product.

191—15.83(507B,522B) Conduct of training course.

15.83(1) The indexed products training shall include information on all topics listed in the most recent version of the indexed products training outline available at the division's Web site, www.iid.state.ia.us.

15.83(2) CE providers of indexed products training shall cover all topics listed in the indexed products training outline and, within the time allotted for the required topics, shall not present any marketing information or provide training on sales techniques or provide specific information about a particular insurer's products. Additional topics may be offered in conjunction with and in addition to the required outline.

15.83(3) The minimum length of the indexed products training must be sufficient to qualify for at least four CE credits, but may be longer.

15.83(4) To satisfy the requirements of subrules 15.83(1), 15.83(2) and 15.83(3), an indexed products training course shall be filed, approved and conducted according to the rules and guidelines applicable to insurance producer continuing education courses as set forth in 191—Chapter 11.

15.83(5) Indexed products training courses may be conducted and completed by classroom or self-study methods according to the rules in 191—Chapter 11.

15.83(6) CE providers of indexed products training shall comply with the reporting requirements as set forth in 191—Chapter 11.

15.83(7) CE providers of indexed products training shall issue certificates of completion according to the rules in 191—Chapter 11.

15.83(8) A producer may use the CE credits completed under the indexed products training requirement to meet the producer's continuing education requirement under 191—Chapter 11.

191—15.84(507B,522B) Insurer duties.

15.84(1) Each insurer shall establish a system to verify which of its appointed insurance producers have completed one training course on indexed products as required in this division.

15.84(2) An insurer shall verify that a producer has completed the required indexed products training before allowing the producer to sell an indexed product for that insurer.

15.84(3) For insurance producers under contract with or employed by a broker-dealer, general agent or independent agency, an insurer may enter into a contract with the broker-dealer, general agent or independent agency to establish and maintain a system of verification as required by subrule 15.84(1) with respect to those insurance producers. In such circumstances, the insurer shall make reasonable inquiry to ensure that the broker-dealer, general agent or independent agency is performing the functions required under subrules 15.84(1) and 15.84(2).

191—15.85(507B,522B) Verification of training. Insurers, producers and third-party contractors may verify a producer's completion of the indexed products training by accessing the division's Web site at www.iid.state.ia.us.

191—15.86(507B,522B) Penalties.

15.86(1) Insurers and third-party contractors that violate the rules of this division are subject to penalty under Iowa Code chapter 507B.

15.86(2) Producers who violate the rules of this division are subject to penalty under Iowa Code chapters 507B and 522B.

15.86(3) Continuing education providers that fail to follow the requirements of the rules of this division and the conduct requirements of 191—Chapter 11 are subject to penalty under 191—Chapter 11 and Iowa Code chapters 507B and 522B.

191—15.87(507B,522B) Compliance date.

15.87(1) A producer who provides advice or makes a sales presentation regarding an indexed product on or after January 1, 2008, shall have completed the indexed products training required by this division.

15.87(2) An Iowa-licensed insurer shall verify that, prior to the sale of any indexed products on or after January 1, 2008, any producer appointed by the insurer has completed the indexed products training required by this division.

Appendix I
LIFE INSURANCE COST AND BENEFIT DISCLOSURE

Definitions.

"Annual premium" for a basic policy or rider, for which the company reserves the right to change the premium, shall be the maximum annual premium.

"Cash dividend" means dividends which can be applied toward payment of gross premiums which comply with the illustrated scale.

"Equivalent level annual dividend" is calculated by applying the following steps:

1. Accumulate the annual cash dividends at 5 percent interest compounded annually to the end of the tenth and twentieth policy years.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the values in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
3. Divide the results of paragraph "2" by the number of thousands of the equivalent level death benefit to arrive at the equivalent level annual dividend.

"Equivalent level death benefit" of a policy or term life insurance rider is an amount calculated as follows:

1. Accumulate the guaranteed amount payable upon death, regardless of the cause of death other than suicide, or other specifically enumerated exclusions, at the beginning of each policy year for 10 and 20 years at 5 percent interest compounded annually to the end of the tenth and twentieth policy years respectively.
2. Divide each accumulation of paragraph "1" by an interest factor that converts it into one equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in paragraph "1" over the respective periods stipulated in paragraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.

"Generic name" means a short title which is descriptive of the premium and benefit patterns of a policy or a rider.

"Life insurance net payment cost index." The life insurance net payment cost index is calculated in the same manner as the comparable life insurance cost index except that the cash surrender value and any terminal dividend are set at zero.

"Life insurance surrender cost index." The life insurance surrender cost index is calculated by applying the following steps:

1. Determine the guaranteed cash surrender value, if any, available at the end of the tenth and twentieth policy years.
2. For participating policies, add the terminal dividend payable upon surrender, if any, to the accumulation of the annual cash dividends at 5 percent interest compounded annually to the end of the period selected and add this sum to the amount determined in subparagraph "1."
3. Divide the result of subparagraph "2" (subparagraph "1" for guaranteed-cost policies) by an interest factor that converts it into an equivalent level annual amount that, if paid at the beginning of each year, would accrue to the value in subparagraph "2" (subparagraph "1" for guaranteed-cost policies) over the respective periods stipulated in subparagraph "1." If the period is 10 years, the factor is 13.207 and if the period is 20 years, the factor is 34.719.
4. Determine the equivalent level premium by accumulating each annual premium payable for the basic policy or rider at 5 percent interest compounded annually to the end of the period stipulated in subparagraph "1" and dividing the result by the respective factors stated in subparagraph "3" (this amount is the annual premium payable for a level premium plan).
5. Subtract the result of subparagraph "3" from subparagraph "4."
6. Divide the result of subparagraph "5" by the number of thousands of the equivalent level death benefit to arrive at the life insurance surrender cost index.

"Policy summary," for the purposes of these rules, shall mean a written statement describing the elements of the policy including but not limited to:

1. A prominently placed title as follows: STATEMENT OF POLICY COST AND BENEFIT INFORMATION.

2. The name and address of the insurance producer or, if no producer is involved, a statement of the procedure to be followed in order to receive responses to inquiries regarding the policy summary.

3. The full name and home office or administrative office address of the company in which the life insurance policy is to be or has been written.

4. The generic name of the basic policy and each rider.

5. The following amounts, where applicable, for the first five policy years and representative policy years thereafter sufficient to clearly illustrate the premium and benefit patterns including, but not necessarily limited to, the years for which life insurance cost indexes are displayed and at least one age from 60 through 65 or maturity, whichever is earlier:

(a) The annual premium for the basic policy.

(b) The annual premium for each optional rider.

(c) Guaranteed amount payable upon death, at the beginning of the policy year regardless of the cause of death other than suicide and other specifically enumerated exclusions, which is provided by the basic policy and each optional rider, with benefits provided under the basic policy and each rider shown separately.

(d) Total guaranteed cash surrender values at the end of the year with values shown separately for the basic policy and each rider.

(e) Cash dividends payable at the end of the year with values shown separately for the basic policy and each rider. (Dividends need not be displayed beyond the twentieth policy year.)

(f) Guaranteed endowment amounts payable under the policy which are not included under guaranteed cash surrender values above.

6. The effective policy loan annual percentage interest rate, if the policy contains this provision, specifying whether this rate is applied in advance or in arrears. If the policy loan interest rate is variable, the policy summary includes the maximum annual percentage rate.

7. Life insurance cost indexes for 10 and 20 years but in no case beyond the premium paying period. Separate indexes are displayed for the basic policy and for each optional term life insurance rider. Such indexes need not be included for optional riders which are limited to benefits such as accidental death benefits, disability waiver of premium, preliminary term life insurance coverage of less than 12 months and guaranteed insurability benefits nor for basic policies or optional riders covering more than one life.

8. The equivalent level annual dividend, in the case of participating policies and participating optional term life insurance riders, under the same circumstances and for the same durations at which life insurance cost indexes are displayed.

9. A policy summary which includes dividends shall also include a statement that dividends are based on the company's illustrated scale and are not guaranteed and a statement in close proximity to the equivalent level annual dividend as follows: An explanation of the intended use of the equivalent level annual dividend is included in the life insurance buyer's guide.

10. A statement in close proximity to the life insurance cost indexes as follows: An explanation of the intended use of these indexes is provided in the life insurance buyer's guide.

11. The date on which the policy summary is prepared.

The policy summary must consist of a separate document. All information required to be disclosed must be set out in such a manner as not to minimize or render any portion thereof obscure. Any amounts which remain level for two or more years of the policy may be represented by a single number if it is clearly indicated what amounts are applicable for each policy year. Amounts in paragraph "5" of this definition shall be listed in total, not a per-thousand nor a per-unit basis. If more than one insured is covered under one policy or rider, guaranteed death benefits shall be displayed separately for each insured or for each class of insured if death benefits do not differ within the class. Zero amounts shall be displayed as zero and shall not be displayed as a blank space.

Appendix II
HIV ANTIBODY TEST
INFORMATION FORM FOR INSURANCE APPLICANT

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and persons who have had sexual contact with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. Infected persons have a 25 percent to 50 percent chance of developing AIDS over the next ten years.

The HIV antibody test:

Before consenting to testing, please read the following important information:

1. Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

2. Positive test results. If you test positive, you should seek medical follow-up with your personal physician. If your test is positive, you may be infected with HIV.

3. Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100 percent accurate. Possible errors include:

a. False positives: This test gives a positive result, even though you are not infected. This happens rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

b. False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

4. Side effects. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies for which you may apply in the future. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results become known to others. A negative result may create a false sense of security.

5. Disclosure of results. A positive test result will be reported to you in one of the following ways. You may choose to have information about a positive test result communicated to you through your physician or through the alternative testing site. If you do not designate a physician or an alternative testing site to receive the information, the information about a positive test result will be reported to the Iowa Department of Public Health, and the Iowa Department of Public Health will contact you.

6. Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. Your test results may be provided to the Medical Information Bureau, a national insurance data bank. Your insurance agent will provide you with additional written information about this subject at your request.

7. Prevention. Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

8. Information. Further information about HIV testing and AIDS can be obtained by calling the national AIDS hotline at 1-800-342-2437.

INFORMED CONSENT

I hereby authorize the company and its designated medical facilities to draw samples of my blood or other bodily fluid for the purpose of laboratory testing to provide applicable medical information concerning my insurability. These tests may include but are not limited to tests for: cholesterol and related blood lipids; diabetes; liver or kidney disorders; infection by the Acquired Immune Deficiency Syndrome (HIV) virus (if permitted by law); immune disorders; or the presence of medications, drugs, nicotine or other metabolites. The tests will be done by a medically accepted procedure which is extremely reliable.

If an HIV Antibody Screen is performed, it will be performed only by a certified laboratory and according to the following medical protocol:

1. An initial ELISA blood or other bodily fluid test will be done.

a. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

b. If the initial ELISA blood or other bodily fluid test is negative, a negative finding will be reported to the company.

2. If the initial ELISA blood or other bodily fluid test is positive, it will be repeated.

a. If the second ELISA blood or other bodily fluid test is also positive, a Western Blot blood or other bodily fluid test will be performed to confirm the positive results of the two ELISA blood or other bodily fluid tests.

b. If the second ELISA blood or other bodily fluid test is negative, a third ELISA blood or other bodily fluid test will be performed. If the third ELISA blood or other bodily fluid test is positive, a Western Blot blood or other bodily fluid test will be performed to confirm the previous positive results. If the third blood or other bodily fluid test is negative, a negative result will be reported to the company.

3. Only if at least two ELISA blood or other bodily fluid tests and a Western Blot blood or other bodily fluid test are all positive will the result be reported as a positive. All other results will be reported as negative to the company.

Without a court order or written authorization from me, these results will be made known only to the company and its reinsurers (if involved in the underwriting process). The company will provide results of all tests to a physician of my choice. Positive test results to the HIV Antibody Screen will be disclosed only to my physician or an alternative testing site as I direct below. If I do not designate a physician or alternative testing site to receive the results, the company will provide results of a positive HIV test to the Iowa Department of Public Health. In addition, the company may make a brief report to MIB, Inc., in a manner described in the Pre-notice which I received as a part of the application process. The only information the company will report to MIB, Inc. is that positive results were obtained from a blood or other bodily fluid test. The company will not report what tests were performed or that the positive result was for HIV antibodies.

These organizations will be the only ones maintaining this information in any type of file except as required by law. Positive HIV Antibody Screen results are to be reported to: (elect one) □ the Alternative Testing Site or □ my physician; _____

(name and address of attending physician)

This authorization will be valid for 90 days from the date below.

Dated At: _____Day _____ Month _____, 19 _____

Witness _____ Proposed Insured: _____

Producer (Signature) (Signature)

This rule is intended to implement Iowa Code section 505.16.

Appendix III
COMPLAINT RECORD

Column A	Column B		Column C	Column D	Column E	Column F	Column G	Column H
Company Identification Number	Function Code	Reason Code	Line Type	Company Disposition after Complaint Received	Date Received	Date Closed	Insurance Division Complaint	State of Origin
(Producer's Number)								

Explanation

A. Company Identification Number. As noted, this refers to the identification number of the complaint and shall also include the license number, name, or other means of identifying any licensee of the Insurance Division, such as a producer that may have been involved in the complaint.

B. Function Code. Complaints are to be classified by function(s) of the company involved. Separate classifications are to be maintained for underwriting, marketing and sales, claims, policyholder service and miscellaneous.
Reason Code. Complaints are also to be classified by the nature of the complaint. The following is the classification required for each function specified above.

1) Underwriting
   a) Premium and rating
   b) Refusal to insure
   c) Cancellation/renewal
   d) Delays
   e) Unfair discrimination
   f) Endorsement/rider
   g) Group conversion
   h) Medicare supplement violation
   i) Miscellaneous (not covered by above)
2) Marketing and Sales
   a) General advertising
   b) Misrepresentation
   c) Producer handling
   d) Replacement
   e) Delays
   f) Miscellaneous (not covered by above)
3) Claims
   a) Post claim underwriting
   b) Delays
   c) Unsatisfactory settlement/offer
   d) Coordination of benefits
   e) Cost containment
   f) Denial of claim
   g) Miscellaneous (not covered by above)
4) Policyholder service
   a) Premium notice/billing
   b) Cash value
   c) Delays/no response
   d) Premium refund
   e) Coverage question
   f) Miscellaneous (not covered by above)

5) Miscellaneous

C. Line Type. Complaints are to be classified according to the line of insurance involved as follows:
1) Automobile
2) Fire
3) Homeowners-Farmowners
4) Crop
5) Life and Annuity
6) Accident and Health
7) Miscellaneous (not covered by above)

D. Company Disposition After Receipt. The complaint record shall note the disposition of the complaint.
The following examples illustrate the type of information called for, but are not intended to be required language nor to exhaust the possibilities:
1. Policy issued/restored.
2. Refund.
3. Claim settled.
4. Delay resolved.
5. Question of fact.
6. Contract provision/legal issue.
7. No jurisdiction.

E. Date Received. This refers to the date the complaint was received.

F. Date Closed. This refers to the date on which the complaint was disposed of whether by one action or a series of actions as may be present in connection with some complaints.

G. Insurance Department Complaint. Complaints are to be classified so as to indicate if the com plaint was from an insurance department.

H. State of Origin. The complaint record should note the state from which the complaint originated. Ordinarily this will be the state of residence of the complainant.

Appendix IV
DISCLOSURE FORM FOR SMALL FACE AMOUNT LIFE INSURANCE POLICIES

Important Information About Your Policy

The premiums you'll pay for your policy may be more than the amount of your coverage (the face amount). You can find both the face amount and the annual premium in your policy. Look for the page labeled [use the label the company uses for that information, such as "Statement of Policy Cost and Benefit Information"].

- Usually, you can figure out how many years it will take until the premiums paid will be greater than the face amount. For an estimate, divide the face amount by the annual premium. Several factors may affect how many years this might take for *your* policy. These include not paying premiums when due, taking out a policy loan, surrendering your policy for cash, policy riders, payment of dividends, if applicable, and changes in the face amount.
- Many factors will affect how much your life insurance costs. Some are your age and health, the face amount of the policy, and the cost of a policy rider. You may be able to pay less for your insurance if you answer health questions. You may also pay less if you pay your premiums less often.
- Ask your insurance agent or your insurance company if you have any questions about your premiums, your coverage, or anything else about your policy.

If You Change Your Mind . . .

- You can get a full refund of premiums you've paid if you return your policy and cancel your coverage. You *must* do this within the number of days stated on your policy's front page. To return the policy for a full refund, send it back to the agent or the company.
- If you stop paying premiums or cancel your policy *after* the time that a full refund is available, you have specific rights. Ask your insurance agent or your insurance company about your rights.

Contact Information

If you have questions about your insurance policy, ask your agent or your company. If your agent isn't available, contact your insurance company at [provide telephone number (including toll-free number if available), address and Web site (if available)].

These rules are intended to implement Iowa Code chapters 507B and 522B.

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◊ Two or more ARCs

1 The Administrative Rules Review Committee at their February 13, 1979, meeting delayed the effective date of rules 15.90 to 15.93 seventy days.

2 Effective date (12/31/81) of rules 15.9 and 15.31 delayed 70 days by the Administrative Rules Review Committee.

3 At its meeting held August 13, 2003, the Administrative Rules Review Committee voted to delay the effective date of 15.43(10) until adjournment of the 2004 Session of the General Assembly.

CHAPTER 37
MEDICARE SUPPLEMENT INSURANCE

DIVISION I
MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

191—37.1(514D) Purpose. The purpose of this chapter is to provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies; to facilitate public understanding and comparison of such policies; to eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and to provide for full disclosures in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

191—37.2(514D) Applicability and scope.

37.2(1) Except as otherwise specifically provided in rules 191—37.6(514D), 191—37.13(514D), 191—37.14(514D), 191—37.17(514D) and 191—37.21(514D), this chapter shall apply to:

a. All Medicare supplement policies delivered or issued for delivery in this state on or after the effective date hereof, and

b. All certificates issued under group Medicare supplement policies, which certificates have been delivered or issued for delivery in this state.

37.2(2) This chapter shall not apply to a policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof; for employees or former employees, or a combination thereof; or for members or former members, or a combination thereof, of the labor organizations.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.3(514D) Definitions. For purposes of this chapter:

"1990 standardized Medicare supplement benefit plan," "1990 standardized benefit plan" or *"1990 plan"* means a group or individual policy of Medicare supplement insurance issued on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010, and includes Medicare supplement insurance policies and certificates renewed on or after June 1, 2010, which are not replaced by the issuer at the request of the insured.

"2010 standardized Medicare supplement benefit plan," "2010 standardized benefit plan" or *"2010 plan"* means a group or individual policy of Medicare supplement insurance issued with an effective date for coverage on or after June 1, 2010.

"Applicant" means:

1. In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and
2. In the case of a group Medicare supplement policy, the proposed certificate holder.

"Bankruptcy" means a Medicare Advantage organization that is not an issuer has filed, or has had filed against it, a petition for declaration of bankruptcy and has ceased doing business in the state.

"Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

"Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Continuous period of creditable coverage" means the period during which an individual was covered by creditable coverage, if during the period of the coverage the individual had no breaks in coverage greater than 63 days.

"Creditable coverage" means, with respect to an individual, coverage of the individual provided under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act (Medicare);

4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928;

5. Chapter 55 of Title 10, United States Code (CHAMPUS);

6. A medical care program of the Indian Health Service or of a tribal organization;

7. A state health benefits risk pool;

8. A health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

9. A public health plan as defined in federal regulation; and

10. A health benefit plan under Section 5(e) of the Peace Corps Act (22 United States Code 2504(e)).

11. A organized delivery system.

12. Short-term limited durational policy.

"Creditable coverage" shall not include one or more, or any combination of, the following:

1. Coverage only for accident or disability income insurance, or any combination thereof;

2. Coverage issued as a supplement to liability insurance;

3. Liability insurance, including general liability insurance and automobile liability insurance;

4. Workers' compensation or similar insurance;

5. Automobile medical payment insurance;

6. Credit-only insurance;

7. Coverage for on-site medical clinics; and

8. Other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

"Creditable coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

1. Limited scope dental or vision benefits;

2. Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; and

3. Such other similar, limited benefits as are specified in federal regulations.

"Creditable coverage" shall not include the following benefits if offered as independent, noncoordinated benefits:

1. Coverage only for a specified disease or illness; and

2. Hospital indemnity or other fixed indemnity insurance.

"Creditable coverage" shall not include the following if it is offered as a separate policy, certificate or contract of insurance:

1. Medicare supplemental health insurance as defined under Section 1882(g)(1) of the Social Security Act;

2. Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

3. Similar supplemental coverage provided to coverage under a group health plan.

"Employee welfare benefit plan" means a plan, fund or program of employee benefits as defined in 29 U.S.C. Section 1002 (Employee Retirement Income Security Act).

"Insolvency" means that an issuer, licensed to transact the business of insurance in this state, has had a final order of liquidation entered against it with a finding of insolvency by a court of competent jurisdiction in the issuer's state of domicile.

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in this state Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as Then Constituted or Later Amended."

"Medicare Advantage plan" means a plan of coverage for health benefits under Medicare Part C (as defined in 42 U.S.C. 1395w-28(b)(1)), and includes:

1. Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans;

2. Medical savings account plans coupled with a contribution into a Medicare Advantage medical savings account; and

3. Medicare Advantage private fee-for-service plans.

"Medicare supplement policy" " means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1), which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare. "Medicare supplement policy" does not include Medicare Advantage plans established under Medicare Part C, Outpatient Prescription Drug plans established under Medicare Part D, or any Health Care Prepayment Plan (HCPP) that provides benefits pursuant to an agreement under §1833(a)(1)(A) of the Social Security Act.

"Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

"Prestandardized Medicare supplement benefit plan" or *"prestandardized plan"* means a group or individual policy of Medicare supplement insurance issued prior to January 1, 1992.

"Secretary" means the Secretary of the United States Department of Health and Human Services.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.4(514D) Policy definitions and terms. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this rule.

"Accident," "accidental injury," or *"accidental means"* shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

1. The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

2. Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

"Benefit period" or *"Medicare benefit period"* shall not be defined more restrictively than as defined in the Medicare program.

"Convalescent nursing home," "extended care facility," or *"skilled nursing facility"* shall not be defined more restrictively than as defined in the Medicare program.

"Health care expenses" means, for purposes of rule 191—37.14(514D), expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare program.

"Medicare" shall be defined in the policy and certificate. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Pub. L. No. 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

"Medicare eligible expenses" shall mean expenses of the kinds covered by Medicare Parts A and B, to the extent recognized as reasonable and medically necessary by Medicare.

"Physician" shall not be defined more restrictively than as defined in the Medicare program.

"Sickness" shall not be defined to be more restrictive than the following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

191—37.5(514D) Policy provisions.

37.5(1) Except for permitted preexisting condition clauses as described in 37.6(1)*"a,"* 37.7(1)*"a,"* and 37.8(1)*"a,"* no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

37.5(2) No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

37.5(3) No Medicare supplement policy or certificate in force in the state shall contain benefits which duplicate benefits provided by Medicare.

37.5(4) Subject to paragraphs 37.6(1)*"d," "e,"* and *"g"* and 37.7(1)*"d"* and *"e,"* a Medicare supplement policy with benefits for outpatient prescription drugs in existence prior to January 1, 2006, shall be renewed for current policyholders who do not enroll in Medicare Part D at the option of the policyholder.

37.5(5) A Medicare supplement policy with benefits for outpatient prescription drugs shall not be issued after December 31, 2005.

37.5(6) After December 31, 2005, a Medicare supplement policy with benefits for outpatient prescription drugs may not be renewed after the policyholder enrolls in Medicare Part D unless:

a. The policy is modified to eliminate outpatient prescription coverage for expenses of outpatient prescription drugs incurred after the effective date of the individual's coverage under a Medicare Part D plan; and

b. Premiums are adjusted to reflect the elimination of outpatient prescription drug coverage at the time of Medicare Part D enrollment, accounting for any claims paid, if applicable.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.6(514D) Minimum benefit standards for prestandardized Medicare supplement benefit plan policies or certificates issued for delivery prior to January 1, 1992. No policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

37.6(1) *General standards*. The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this regulation.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. A "noncancelable," "guaranteed renewable," or "noncancelable and guaranteed renewable" Medicare supplement policy shall not:

(1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(2) Be canceled or nonrenewed by the issuer solely on the grounds of deterioration of health.

e. (1) Except as authorized by the commissioner of this state, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

(2) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subparagraph *"e"*(4) below, the issuer shall offer certificate holders an individual Medicare supplement policy. The issuer shall offer the certificate holder at least the following choices:

1. An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

2. An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in 37.7(2).

(3) If membership in a group is terminated, the issuer shall:

1. Offer the certificate holder such conversion opportunities as are described in 37.6(1)*"e"*(2); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(4) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(5) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

37.6(2) *Minimum benefit standards.*

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

c. Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

d. Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 90 percent of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

e. Coverage under Medicare Part A for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

f. Coverage for the coinsurance amount, or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($100);

g. Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for under Part A, subject to the Medicare deductible amount.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.7(514D) Benefit standards for 1990 standardized Medicare supplement benefit plan policies or certificates issued for delivery on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state on or after January 1, 1992, and with an effective date for coverage prior to June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards.

37.7(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each Medicare supplement policy shall be guaranteed renewable and

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under 37.7(1)*"e"*(5), the issuer shall offer certificate holders an individual Medicare supplement policy which at the option of the certificate holder:

1. Provides for continuation of the benefits contained in the group policy, or
2. Provides for such benefits as otherwise meets the requirements of this subrule.

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in 37.7(1)*"e"*(3), or
2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(6) If a Medicare supplement policy eliminates an outpatient prescription drug benefit as a result of requirements imposed by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the modified policy shall be deemed to satisfy the guaranteed renewal requirements of this subrule.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g. (1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of such policy or certificate within 90 days after the date the individual becomes entitled to such assistance.

(2) If such suspension occurs and if the policyholder or certificate holder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificate holder provides notice of loss of such entitlement within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(3) Reinstitution of such coverages:

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension. If the suspended Medicare supplement policy provided coverage for outpatient prescription drugs, reinstitution of the policy for Medicare Part D enrollees shall be without coverage for outpatient prescription drugs and shall otherwise provide substantially equivalent coverage to the coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

(4) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended for the period provided by federal regulation at the request of the policyholder if the policyholder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan as defined in Section 1862(b)(1)(A)(v) of the Social Security Act. If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted effective as of the date of loss of coverage if the policyholder provides notice of loss of coverage within 90 days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

h. If an issuer makes a written offer to an insured who holds one or more of the issuer's 1990 Standardized Medicare supplement policies or certificates (as described in rule 191—37.9(514D)) to allow the insured to exchange that policy during a specified period of time for a 2010 standardized plan (as described in rule 191—37.10(514D)), the offer and subsequent exchange shall comply with the following requirements:

(1) An issuer need not provide justification to the commissioner if the insured exchanges a 1990 standardized policy or certificate for an issue-age-rated 2010 standardized policy or certificate at the insured's original issue age and duration. If an insured's 1990 standardized policy or certificate to be exchanged is priced on an issue-age rate schedule at the time of such offer, the rate charged to the insured for the new 2010 exchanged standardized policy or certificate shall recognize the policy reserve buildup, due to the prefunding inherent in the use of an issue-age rate basis, for the benefit of the insured. The method proposed to be used by an issuer must be filed with the commissioner pursuant to rule 191—37.15(514D).

(2) The rating class of the new 2010 standardized policy or certificate shall be the class closest to the insured's class of the replaced coverage.

(3) An issuer may not apply new preexisting condition limitations or a new incontestability period to the new 2010 standardized policy or certificate for those benefits contained in the exchanged 1990 standardized policy or certificate of the insured, but may apply preexisting condition limitations of no more than six months to any added benefits contained in the new 2010 standardized policy or certificate not contained in the exchanged 1990 standardized policy or certificate.

(4) The new 2010 standardized policy or certificate shall be offered to all policyholders or certificate holders within a given plan, except where the offer or issue would be in violation of state or federal law.

37.7(2) *Standards for Basic ("Core") Benefits Common to A-J Benefit Plans.* Every issuer shall make available a policy or certificate including only the following basic "Core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic "Core" package, but not in lieu thereof.

a. Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of 100 percent of the Medicare Part A Eligible Expenses for hospitalization paid at the applicable prospective payment system (PPS) rate or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount or in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

37.7(3) *Standards for Additional Benefits.* The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by 191—37.9(514D).

a. Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

b. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredth day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

c. Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

d. Eighty percent of the Medicare Part B Excess Charges: Coverage for 80 percent of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

e. One hundred percent of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

f. Basic Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible, to a maximum of $1,250 in benefits received by the insured per calendar year to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

g. Extended Outpatient Prescription Drug Benefit: Coverage for 50 percent of outpatient prescription drug charges, after a $250 calendar year deductible to a maximum of $3,000 in benefits received by the insured per calendar year, to the extent not covered by Medicare. The outpatient prescription drug benefit may be included for sale or issuance in a Medicare supplement policy until January 1, 2006.

h. Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250 and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

i. Preventive Medical Care Benefit: Coverage for the following preventive health services not covered by Medicare:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from subparagraph (2) and patient education to address preventive health care measures.

(2) Preventive screening tests or preventive services, the selection and frequency of which is determined to be medically appropriate by the attending physician.

Reimbursement shall be for the actual charges up to 100 percent of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of $120 annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

j. At-Home Recovery Benefit: Coverage for services to provide short-term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of this benefit, the following definitions shall apply:

1. "Activities of daily living" include, but are not limited to, bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

2. "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

3. "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

4. "At-home recovery visit" means the period of a visit required to provide at-home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(2) Coverage requirements and limitations.

1. At-home recovery services provided must be primarily services which assist in activities of daily living.

2. The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

3. Coverage is limited to:

- No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare-approved home health care visits under a Medicare-approved home care plan of treatment.
- The actual charges for each visit up to a maximum reimbursement of $40 per visit.
- One thousand six hundred dollars per calendar year.
- Seven visits in any one week.
- Care furnished on a visiting basis in the insured's home.
- Services provided by a care provider as defined in this paragraph *"j."*
- At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.
- At-home recovery visits received during the period the insured is receiving Medicare-approved home care services or no more than eight weeks after the service date of the last Medicare-approved home health care visit.

(3) Coverage is excluded for:

1. Home care visits paid for by Medicare or other government programs; and

2. Care provided by family members, unpaid volunteers or providers who are not care providers.

k. Rescinded IAB 1/5/05, effective 2/9/05.

37.7(4) *Standards for Plan "K."* Standardized Medicare supplement benefit plan "K" shall consist of the following:

a. Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

b. Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment in full and may not bill the insured for any balances;

d. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in paragraph *"j"*;

e. Skilled Nursing Facility Care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in paragraph *"j"*;

f. Hospice Care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in paragraph *"j"*;

g. Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in paragraph *"j"*;

h. Except for coverage provided in paragraph *"i,"* coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder pays the Part B deductible until the out-of-pocket limitation is met as described in paragraph *"j"*;

i. Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder pays the Part B deductible; and

j. Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4,000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

37.7(5) *Standards for Plan "L."* Standardized Medicare supplement benefit plan "L" shall consist of the following:

a. The benefits described in paragraphs 37.7(4)*"a," "b," "c,"* and *"i"*;

b. The benefits described in paragraphs 37.7(4)*"d," "e," "f," "g,"* and *"h"* but substituting 75 percent for 50 percent; and

c. The benefits described in paragraph 37.7(4)*"j"* but substituting $2,000 for $4,000.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.8(514D) Benefit standards for 2010 standardized Medicare supplement benefit plan policies or certificates issued for delivery with an effective date for coverage on or after June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. Insurers may begin submitting policies and certificates to the division for approval on or after January 1, 2010. No policy or certificate may be advertised, solicited, delivered, or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit standards. No issuer may offer any 1990 standardized Medicare supplement benefit plan for sale on or after June 1, 2010. Benefit standards applicable to Medicare supplement policies and certificates issued with an effective date for coverage prior to June 1, 2010, remain subject to the requirements of rule 191—37.7(514D).

37.8(1) *General standards.* The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

a. A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage.

b. A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

c. A Medicare supplement policy or certificate shall provide that benefits designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible, copayment, or coinsurance amounts. Premiums may be modified to correspond with such changes.

d. No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

e. Each Medicare supplement policy shall be guaranteed renewable.

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual.

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 37.8(1)*"e"*(5), the issuer shall offer certificate holders an individual Medicare supplement policy which (at the option of the certificate holder):

1. Provides for continuation of the benefits contained in the group policy; or

2. Provides for benefits that otherwise meet the requirements of paragraph 37.8(1)*"e."*

(4) If an individual is a certificate holder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

1. Offer the certificate holder the conversion opportunity described in subparagraph 37.8(1)*"e"*(3); or

2. At the option of the group policyholder, offer the certificate holder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the issuer of the replacement policy shall offer coverage to all persons covered under the group policy that is being replaced on that policy's date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

f. Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits. Receipt of Medicare Part D benefits will not be considered in determining a continuous loss.

g. Suspension of benefits.

(1) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificate holder for the period (not to exceed 24 months) in which the policyholder or certificate holder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificate holder notifies the issuer of the policy or certificate within 90 days after the date the individual becomes entitled to assistance.

(2) If suspension occurs and if the policyholder or certificate holder loses entitlement to medical assistance, the policy or certificate shall be automatically reinstituted effective as of the date of termination of entitlement if the policyholder or certificate holder provides notice of loss of entitlement within 90 days after the date of loss and pays the premium attributable to the period, effective as of the date of termination of entitlement.

(3) Each Medicare supplement policy shall provide that benefits and premiums under the policy shall be suspended (for any period that may be provided by federal regulation) at the request of the policyholder or certificate holder if the policyholder or certificate holder is entitled to benefits under Section 226(b) of the Social Security Act and is covered under a group health plan (as defined in Section 1862(b)(1)(A)(v) of the Social Security Act). If suspension occurs and if the policyholder or certificate holder loses coverage under the group health plan, the policy shall be automatically reinstituted (effective as of the date of loss of coverage) if the policyholder or certificate holder provides notice of loss of coverage within 90 days after the date of the loss.

(4) Reinstitution of coverage as described in subparagraphs 37.8(1)*"g"*(2) and (3):

1. Shall not provide for any waiting period with respect to treatment of preexisting conditions;

2. Shall provide for resumption of coverage that is substantially equivalent to coverage in effect before the date of suspension; and

3. Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage not been suspended.

37.8(2) *Standards for basic (core) benefits common to Medicare supplement insurance benefit plans A, B, C, D, F, F with high deductible, G, M, and N.* Every issuer of Medicare supplement insurance benefit plans shall make available to each prospective insured a policy or certificate including only the following basic (core) package of benefits. An issuer may make available to prospective insureds any of the other Medicare supplement insurance benefit plans in addition to the basic core package, but not in lieu of it. The basic core package must provide:

a. Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the sixty-first day through the ninetieth day in any Medicare benefit period;

b. Coverage of Part A Medicare eligible expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

c. Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

d. Coverage under Medicare Parts A and B for the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

e. Coverage for the coinsurance amount or, in the case of hospital outpatient department services paid under a prospective payment system, the copayment amount, of Medicare eligible expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible; and

f. Hospice Care: Coverage of cost sharing for all Part A Medicare eligible hospice care and respite care expenses.

37.8(3) *Standards for additional benefits.* The following additional benefits shall be included in Medicare supplement benefit Plans B, C, D, F, F with high deductible, G, M, and N as provided by rule 191—37.10(514D):

a. Medicare Part A Deductible: Coverage for 100 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

b. Medicare Part A Deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period;

c. Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the twenty-first day through the one hundredeth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A;

d. Medicare Part B Deductible: Coverage for 100 percent of the Medicare Part B deductible amount per calendar year regardless of hospital confinement;

e. One hundred percent of the Medicare Part B excess charges: Coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge; and

f. Medically necessary emergency care in a foreign country: Coverage to the extent not covered by Medicare for 80 percent of the billed charges for Medicare eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first 60 consecutive days of each trip outside the United States, subject to a calendar year deductible of $250, and a lifetime maximum benefit of $50,000. For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.9(514D) Standard Medicare supplement benefit plans for 1990 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage prior to June 1, 2010.

37.9(1) An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic "Core" benefits as defined in 37.7(2).

37.9(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in 37.9(7) and in 191—37.11(514D).

37.9(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans "A" through "L" listed in this rule and conform to the definitions in 191—37.3(514D). Each benefit shall be structured in accordance with the format provided in 37.7(2), 37.7(3), 37.7(4) and 37.7(5) and list the benefits in the order shown in this rule. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

37.9(4) An issuer may use, in addition to the benefit plan designations required in 37.8(3), other designations to the extent permitted by law.

37.9(5) Makeup of benefit plans:

a. Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits Common to All Benefit Plans, as defined in 37.7(2).

b. Standardized Medicare supplement benefit plan "B" shall include only the following: The Core Benefit as defined in 37.7(2), plus the Medicare Part A Deductible as defined in 37.7(3)*"a."*

c. Standardized Medicare supplement benefit plan "C" shall include only the following: The Core Benefit as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "c,"* and *"h,"* respectively.

d. Standardized Medicare supplement benefit plan "D" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and the At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "h,"* and *"j,"* respectively.

e. Standardized Medicare supplement benefit plan "E" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in 37.7(3)*"a," "b," "h,"* and *"i,"* respectively.

f. Standardized Medicare supplement benefit plan "F" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "c," "e,"* and *"h,"* respectively.

g. Standardized Medicare supplement benefit plan "G" shall include only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 80 Percent of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a

Foreign Country, and the At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "d," "h,"* and *"j,"* respectively.

h. Standardized Medicare supplement benefit plan "H" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "f,"* and *"h,"* respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

i. Standardized Medicare supplement benefit plan "I" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, 100 Percent of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "e," "f," "h,"* and *"j,"* respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

j. Standardized Medicare supplement benefit plan "J" shall consist of only the following: The Core Benefit, as defined in 37.7(2), plus the Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, 100 Percent of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "c," "e," "g," "h," "i,"* and *"j,"* respectively. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

k. Standardized Medicare supplement benefit high deductible plan "F" shall include only the following: 100 percent of covered expenses following the payment of the annual high deductible plan "F" deductible. The covered expenses include the Core Benefit as defined in subrule 37.7(2), plus the Medicare Part A Deductible Skilled Nursing Facility Care, the Medicare Part B Deductible, 100 percent of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in 37.7(3)*"a," "b," "c," "e,"* and *"h,"* respectively. The annual high deductible plan "F" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare Supplement plan "F" policy, and shall be in addition to any other specific benefit deductibles. The annual high deductible plan "F" deductible shall be $1500 for 1998 and 1999, and shall be based on the calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10.

l. Standardized Medicare supplement benefit high deductible plan "J" shall consist only of the following: 100 percent of covered expenses following the payment of the annual high deductible plan "J" deductible. The covered expenses include the Core Benefit as defined in 37.7(2), plus the Medicare Part A deductible, Skilled Nursing Facility Care, Medicare Part B deductible, 100 percent of the Medicare Part B Excess Charges, Extended Outpatient Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care Benefit and At-Home Recovery Benefit as defined in 37.7(3)*"a," "b," "c," "e," "g," "h," "i,"* and *"j,"* respectively. The annual high deductible plan "J" deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by the Medicare supplement plan "J" policy, and shall be in addition to any other specific benefit deductibles. The annual deductible shall be $1,500 for 1998 and 1999, and shall be based on a calendar year. It shall be adjusted annually thereafter by the Secretary to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of $10. The outpatient prescription drug benefit shall not be included in a Medicare supplement policy sold after December 31, 2005.

37.9(6) Standardized Medicare supplement benefit plan "K" mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(4). Standardized Medicare supplement benefit plan "L" mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall consist of only those benefits described in subrule 37.7(5).

37.9(7) New or Innovative Benefits: An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies. After December 31, 2004, the innovative benefit shall not include an outpatient prescription drug benefit.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.10(514D) Standard Medicare supplement benefit plans for 2010 standardized Medicare supplement benefit plan policies or certificates with an effective date for coverage on or after June 1, 2010. The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this state with an effective date for coverage on or after June 1, 2010. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this state as a Medicare supplement policy or certificate unless it complies with these benefit plan standards. Benefit plan standards applicable to Medicare supplement policies and certificates with an effective date for coverage before June 1, 2010, remain subject to the requirements of rules 191—37.6(514D) and 191—37.9(514D).

37.10(1) Issuer to make form available.

a. An issuer shall make available to each prospective policyholder and certificate holder a policy form or certificate form containing only the basic (core) benefits, as defined in subrule 37.8(2).

b. If an issuer makes available any of the additional benefits described in subrule 37.8(3) or offers standardized benefit Plans K or L (as described in paragraphs 37.10(5)*"h"* and *"i"*), then the issuer shall make available to each prospective policyholder and certificate holder, in addition to a policy form or certificate form with only the basic (core) benefits as described in paragraph 37.10(1)*"a,"* a policy form or certificate form containing either standardized benefit Plan C (as described in paragraph 37.10(5)*"c"*) or standardized benefit Plan F (as described in paragraph 37.10(5)*"e"*).

37.10(2) No groups, packages or combinations of Medicare supplement benefits other than those listed in this rule shall be offered for sale in this state, except as may be permitted in subrule 37.10(6) and rule 191—37.11(514D).

37.10(3) Benefit plans shall be uniform in structure, language, designation and format to the standard benefit plans listed in rule 191—37.10(514D) and conform to the definitions in rule 191—37.3(514D). Each benefit plan shall be structured in accordance with the format provided in subrules 37.8(2) and 37.8(3), or, in the case of Plan K or L, each benefit plan shall be structured in accordance with the format provided in paragraphs 37.10(5)*"h"* and *"i."* Each plan shall list the benefits in the order shown. For purposes of this rule, "structure, language, and format" means style, arrangement and overall content of a benefit.

37.10(4) In addition to the benefit plan designations required in subrule 37.10(3), an issuer may use other designations to the extent permitted by law.

37.10(5) Makeup of 2010 standardized benefit plans.

a. Standardized Medicare supplement benefit Plan A shall include only the following: The basic (core) benefits as defined in subrule 37.8(2).

b. Standardized Medicare supplement benefit Plan B shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible as defined in paragraph 37.8(3)*"a."*

c. Standardized Medicare supplement benefit Plan C shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d,"* and *"f,"* respectively.

d. Standardized Medicare supplement benefit Plan D shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible,

skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c,"* and *"f,"* respectively.

e. Standardized Medicare supplement (regular) Plan F shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d," "e,"* and *"f,"* respectively.

f. Standardized Medicare supplement Plan F with high deductible shall include only the following: 100 percent of covered expenses following the payment of the annual deductible set forth in subparagraph 37.10(5)*"f"*(2).

(1) The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "d," "e,"* and *"f,"* respectively.

(2) The annual deductible in Plan F with high deductible shall consist of out-of-pocket expenses, other than premiums, for services covered by (regular) Plan F, and shall be in addition to any other specific benefit deductibles. The basis for the deductible shall be $1,500 and shall be adjusted annually from 1999 by the Secretary of the U.S. Department of Health and Human Services to reflect the change in the consumer price index for all urban consumers for the 12-month period ending with August of the preceding year, and rounded to the nearest multiple of ten dollars.

g. Standardized Medicare supplement benefit Plan G shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c," "e,"* and *"f,"* respectively.

h. Standardized Medicare supplement Plan K is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) Part A hospital coinsurance from the sixty-first through ninetieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each day used from the sixty-first through the ninetieth day in any Medicare benefit period;

(2) Part A hospital coinsurance from the ninety-first through one hundred fiftieth day: Coverage of 100 percent of the Part A hospital coinsurance amount for each Medicare lifetime inpatient reserve day used from the ninety-first through the one hundred fiftieth day in any Medicare benefit period;

(3) Part A hospitalization after 150 days: Upon exhaustion of the Medicare hospital inpatient coverage, including the lifetime reserve days, coverage of 100 percent of the Medicare Part A eligible expenses for hospitalization paid at the applicable prospective payment system (PPS) rate, or other appropriate Medicare standard of payment, subject to a lifetime maximum benefit of an additional 365 days. The provider shall accept the issuer's payment as payment in full and may not bill the insured for any balance;

(4) Medicare Part A deductible: Coverage for 50 percent of the Medicare Part A inpatient hospital deductible amount per benefit period until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(5) Skilled nursing facility care: Coverage for 50 percent of the coinsurance amount for each day used from the twenty-first day through the one hundredeth day in a Medicare benefit period for post-hospital skilled nursing facility care eligible under Medicare Part A until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(6) Hospice care: Coverage for 50 percent of cost sharing for all Part A Medicare eligible expenses and respite care until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(7) Blood: Coverage for 50 percent, under Medicare Part A or B, of the reasonable cost of the first three pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(8) Part B cost sharing: Except for coverage provided in subparagraph 37.10(5)*"h"*(9), coverage for 50 percent of the cost sharing otherwise applicable under Medicare Part B after the policyholder or certificate holder pays the Part B deductible until the out-of-pocket limitation is met as described in subparagraph 37.10(5)*"h"*(10);

(9) Part B preventive services: Coverage of 100 percent of the cost sharing for Medicare Part B preventive services after the policyholder or certificate holder pays the Part B deductible; and

(10) Cost sharing after out-of-pocket limits: Coverage of 100 percent of all cost sharing under Medicare Parts A and B for the balance of the calendar year after the individual has reached the out-of-pocket limitation on annual expenditures under Medicare Parts A and B of $4000 in 2006, indexed each year by the appropriate inflation adjustment specified by the Secretary of the U.S. Department of Health and Human Services.

i. Standardized Medicare supplement Plan L is mandated by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, and shall include only the following:

(1) The benefits described in subparagraphs 37.10(5)*"h"*(1), (2), (3) and (9);

(2) The benefits described in subparagraphs 37.10(5)*"h"*(4), (5), (6), (7) and (8), but substituting 75 percent for 50 percent; and

(3) The benefit described in subparagraph 37.10(5)*"h"*(10), but substituting $2000 for $4000.

j. Standardized Medicare supplement Plan M shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 50 percent of the Medicare Part A deductible, 100 percent of skilled nursing facility care, and 100 percent of medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"b," "c,"* and *"f,"* respectively.

k. Standardized Medicare supplement Plan N shall include only the following: The basic (core) benefit as defined in subrule 37.8(2), plus 100 percent of the Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country as defined in paragraphs 37.8(3)*"a," "c,"* and *"f,"* respectively, with copayments in the following amounts:

(1) The lesser of $20 or the Medicare Part B coinsurance or copayment for each covered health care provider office visit (including visits to medical specialists); and

(2) The lesser of $50 or the Medicare Part B coinsurance or copayment for each covered emergency room visit; however, this copayment shall be waived if the insured is admitted to any hospital and the emergency visit is subsequently covered as a Medicare Part A expense.

37.10(6) New or innovative benefits. An issuer may, with the prior approval of the commissioner, offer policies or certificates with new or innovative benefits, in addition to the standardized benefits provided in a policy or certificate that otherwise complies with the applicable standards. The new or innovative benefits shall include only benefits that are appropriate to Medicare supplement insurance, are new or innovative, are not otherwise available, and are cost-effective. Approval of new or innovative benefits must not adversely impact the goal of Medicare supplement simplification. New or innovative benefits shall not include an outpatient prescription drug benefit. New or innovative benefits shall not be used to change or reduce benefits, including a change of any cost-sharing provision, in any standardized plan. The commissioner shall use any guidelines issued by the National Association of Insurance Commissioners in determining whether to approve new or innovative benefits.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.11(514D) Medicare Select policies and certificates.

37.11(1) *a.* Rule 191—37.11(514D) shall apply to Medicare Select policies and certificates, as defined in this rule.

b. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this rule.

37.11(2) For the purposes of this rule:

a. "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

b. *"Grievance"* means dissatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of services concerning a Medicare Select issuer or its network providers.

c. *"Medicare Select Issuer"* means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

d. *"Medicare Select Policy"* or *"Medicare Select Certificate"* means respectively, a Medicare supplement policy or certificate that contains restricted network provisions.

e. *"Network Provider"* means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

f. *"Restricted Network Provision"* means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

g. *"Service Area"* means the geographic area approved by the commissioner within which an issuer is authorized to offer a Medicare Select policy.

37.11(3) The commissioner may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this rule and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, if the commissioner finds that the issuer has satisfied all of the requirements.

37.11(4) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this state until its plan of operation has been approved by the commissioner.

37.11(5) A Medicare Select issuer shall file a proposed plan of operation with the commissioner in a format prescribed by the commissioner. The plan of operation shall contain at least the following information:

a. Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

(1) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

(2) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

1. To adequately deliver all services that are subject to a restricted network provision; or
2. To make appropriate referrals.

(3) There are written agreements with network providers describing specific responsibilities.

(4) Emergency care is available 24 hours per day and seven days per week.

(5) In the case of covered services that are subject to a restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This paragraph shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

b. A statement or map providing a clear description of the service area.

c. A description of the grievance procedure to be utilized.

d. A description of the quality assurance program, including:

(1) The formal organizational structure;

(2) The written criteria for selection, retention and removal of network providers; and

(3) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

e. A list and description, by specialty, of the network providers.

f. Copies of the written information proposed to be used by the issuer to comply with 37.11(9).

g. Any other information requested by the commissioner.

37.11(6) *a.* A Medicare Select issuer shall file any proposed changes to the plan of operation, except for changes to the list of network providers, with the commissioner prior to implementing

such changes. Such changes shall be considered approved by the commissioner after 30 days unless specifically disapproved.

b. An updated list of network providers shall be filed with the commissioner at least quarterly.

37.11(7) A Medicare Select policy or certificate shall not restrict payment for covered services provided by nonnetwork providers if:

a. The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and

b. It is not reasonable to obtain such services through a network provider.

37.11(8) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

37.11(9) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

a. An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

(1) Other Medicare supplement policies or certificates offered by the issuer; and

(2) Other Medicare Select policies or certificates.

b. A description (including address, telephone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals and other providers.

c. A description of the restricted network provisions, including payments for coinsurance and deductibles, when providers other than network providers are utilized. Except to the extent specified in the policy or certificate, expenses incurred when using out-of-network providers do not count toward the out-of-pocket annual limit contained in plans "K" and "L."

d. A description of coverage for emergency and urgently needed care and other out-of-service area coverage.

e. A description of limitations on referrals to restricted network providers and to other providers.

f. A description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

g. A description of the Medicare Select issuer's quality assurance program and grievance procedure.

37.11(10) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to 37.11(9) and that the applicant understands the restrictions of the Medicare Select policy or certificate.

37.11(11) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

a. The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

b. At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

c. Grievances shall be considered in a timely manner and shall be transmitted to appropriate decision makers who have authority to fully investigate the issue and take corrective action.

d. If a grievance is found to be valid, corrective action shall be taken promptly.

e. All concerned parties shall be notified about the results of a grievance.

f. The issuer shall report no later than each March 31 to the commissioner regarding its grievance procedure. The report shall be in a format prescribed by the commissioner and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

37.11(12) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

37.11(13) *a.* At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select policy or certificate has been in force for six months.

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

37.11(14) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this section should be discontinued due to either the failure of the Medicare Select program to be reauthorized under law or its substantial amendment.

a. Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.

b. For the purposes of this subrule, a Medicare supplement policy or certificate will be considered to have comparable or lesser benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this paragraph, a significant benefit means coverage for the Medicare Part A deductible, coverage for at-home recovery services or coverage for Part B excess charges.

37.11(15) A Medicare Select issuer shall comply with reasonable requests for data made by state or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select program.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.12(514D) Open enrollment.

37.12(1) No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this state, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of an application for a policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under this subrule without regard to age.

37.12(2) If an applicant under subrule 37.12(1) submits an application during the time period referenced in subrule 37.12(1) and, as of the date of application, has had a continuous period of creditable coverage of at least six months, the issuer shall not exclude benefits based on a preexisting condition.

If the applicant qualifies under subrule 37.12(1) and submits an application during the time period referenced in subrule 37.12(1) and, as of the date of application, has had a continuous period of creditable coverage that is less than six months, the issuer shall reduce the period of any preexisting condition exclusion by the aggregate of the period of creditable coverage applicable to the applicant as of the enrollment date. The secretary shall specify the manner of the reduction under this subrule.

37.12(3) Except as provided in 191—37.22(514D) or 191—37.25(514D), subrule 37.12(1) shall not be construed as preventing the exclusion of benefits under a policy, during the first six months, based

on a preexisting condition for which the policyholder or certificate holder received treatment or was otherwise diagnosed during the six months before the coverage became effective.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.13(514D) Standards for claims payment.

37.13(1) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

a. Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

b. Notifying the participating physician or supplier and the beneficiary of the payment determination;

c. Paying the participating physician or supplier directly;

d. Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

e. Paying user fees for claim notices that are transmitted electronically or otherwise; and

f. Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

37.13(2) Compliance with the requirements set forth in 37.13(1) shall be certified on the Medicare supplement insurance experience reporting form.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.14(514D) Loss ratio standards and refund or credit of premium.

37.14(1) *Loss ratio standards.*

a. A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(1) At least 75 percent of the aggregate amount of premiums earned in the case of group policies, or

(2) At least 65 percent of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices. Incurred health care expenses where coverage is provided by a health maintenance organization shall not include:

1. Home office and overhead costs;
2. Advertising costs;
3. Commissions and other acquisition costs;
4. Taxes;
5. Capital costs;
6. Administrative costs; and
7. Claims processing costs.

b. All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this rule when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

c. For all policies issued prior to January 1, 1992, expected claims in relation to premiums shall meet:

(1) The originally filed anticipated loss ratio when combined with the actual experience from inception;

(2) The appropriate loss ratio requirement from 37.14(1)*"a"*(1) and (2) when combined with actual experience beginning with January 1, 1996, to date; and

(3) The appropriate loss ratio requirement from 37.14(1)*"a"*(1) and (2) over the entire future period for which rates are computed to provide coverage.

37.14(2) *Refund or credit calculation.*

a. An issuer shall collect and file with the commissioner by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a standard Medicare supplement benefit plan.

b. If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

c. For purposes of this subrule, policies or certificates issued prior to January 1, 1992, the issuer shall make the refund calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after January 1, 1996. The first report shall be due May 31, 1998.

d. A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

37.14(3) *Annual filing of premium rates.* An issuer of Medicare supplement policies and certificates issued before or after the effective date of January 1, 1992, in this state shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner. The supporting documentation shall also demonstrate in accordance with actuarial standards of practice using reasonable assumptions that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three years.

As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this state shall file with the commissioner in accordance with the applicable filing procedures of this state:

a. (1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

(2) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

(3) If an issuer fails to make premium adjustments acceptable to the commissioner, the commissioner may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this rule.

b. Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

37.14(4) *Public hearings.* The commissioner may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of January 1, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period. Public notice of such hearing shall be furnished in a manner deemed appropriate by the commissioner.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.15(514D) Filing and approval of policies and certificates and premium rates.

37.15(1) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this state unless the policy form or certificate form has been filed pursuant to rule 191—20.1(505,509,514A,515,515A,515F) and approved by the commissioner.

37.15(2) An issuer shall file any riders or amendments to policy or certificate forms to delete outpatient prescription drug benefits as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 only with the commissioner in the state in which the policy or certificate was issued.

37.15(3) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the commissioner in accordance with the filing requirements and procedures prescribed by the commissioner.

37.15(4) *a.* Except as provided in paragraph *"b"* of this subrule, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

b. An issuer may offer, with the approval of the commissioner, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

(1) The inclusion of new or innovative benefits;

(2) The addition of either direct response or agent marketing methods;

(3) The addition of either guaranteed issue or underwritten coverage;

(4) The offering of coverage to individuals eligible for Medicare by reason of disability.

c. For the purposes of this section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

37.15(5) *a.* Except as provided in subparagraph *"a"*(1) below, an issuer shall continue to make available for purchase any policy form or certificate form issued after January 1, 1992, that has been approved by the commissioner. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous 12 months.

(1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the commissioner in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the commissioner, the issuer shall no longer offer for sale the policy form or certificate form in this state.

(2) An issuer that discontinues the availability of a policy form or certificate form pursuant to subparagraph *"a"*(1) above shall not file for approval of a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the commissioner of the discontinuance. The period of discontinuance may be reduced if the commissioner determines that a shorter period is appropriate.

b. The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subrule.

c. A change in the rating structure or methodology shall be considered a discontinuance under paragraph *"a"* of this subrule unless the issuer complies with the following requirements:

(1) The issuer provides an actuarial memorandum, in a form and manner prescribed by the commissioner, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and resultant rates.

(2) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change. The commissioner may approve a change to the differential which is in the public interest.

37.15(6) *a.* Except as provided in paragraph *"b"* of this subrule, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in 191—37.14(514D).

b. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.16(514D) Permitted compensation arrangements.

37.16(1) An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first-year commission or other first-year compensation is no more than 200 percent of the commission or other compensation paid for selling or servicing the policy or certificate i n the second year or period.

37.16(2) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

37.16(3) No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

37.16(4) For purposes of this rule, "compensation" includes pecuniary or nonpecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including, but not limited to, bonuses, gifts, prizes, awards and finders fees.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.17(514D) Required disclosure provisions.

37.17(1) *General rules.*

a. Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provisions shall be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy, and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

b. Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, or if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

c. Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

d. If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

e. Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificate holder shall have the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

f. (1) Issuers of accident and sickness policies, or certificates which provide hospital or medical expense coverage on an expense-incurred or indemnity basis to a person(s) eligible for Medicare shall provide to those applicants a Guide to Health Insurance for People with Medicare in the form developed jointly by the National Association of Insurance Commissioners and CMS and in a type size no smaller than 12-point type. Delivery of the Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter. Except in the case of direct response issuers, delivery of the Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Guide shall be obtained by the issuer. Direct response issuers shall deliver the Guide to the applicant upon request but not later than at the time the policy is delivered.

(2) For the purposes of this rule, "form" means the language, format, type size, type proportional spacing, bold character and line spacing.

37.17(2) *Notice requirements.*

a. As soon as practicable, but no later than 30 days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificate holders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the commissioner.

(1) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

(2) Inform each policyholder or certificate holder as to when any premium adjustment is to be made due to changes in Medicare.

b. The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

c. Such notices shall not contain or be accompanied by any solicitation.

37.17(3) *MMA notice requirements.* Issuers shall comply with any notice requirements of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

37.17(4) *Outline of coverage requirements for Medicare supplement policies.*

a. Issuers shall provide an outline of coverage to all applicants at the time application is presented to the prospective applicant and, except for direct response policies, shall obtain an acknowledgment of receipt of such outline from the applicant; and

b. If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than 12-point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

c. The outline of coverage provided to applicants pursuant to this subrule consists of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. The outline of coverage shall be in the language and format prescribed below in no less than 12-point type. All plans shall be shown on the cover page, and the plans that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed.

The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

d. The following items shall be included in the outline of coverage in the order prescribed below.

Benefit Chart of Medicare Supplement Plans Sold for Effective Dates on or After June 1, 2010

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state.

Plans E, H, I, and J are no longer available for sale. [This sentence shall not appear after June 1, 2011.]

Basic Benefits:

- **Hospitalization** – Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses** – Part B coinsurance (generally 20% of Medicare-approved expenses) or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments.
- **Blood** – First three pints of blood each year.
- **Hospice** – Part A coinsurance.

A	B	C	D	F	F*	G	K	L	M	N
Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance*		Basic, including 100% Part B co-insurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B co-insurance	Basic, including 100% Part B co-insurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
		Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance		Skilled Nursing Facility Co-insurance	50% Skilled Nursing Facility Co-insurance	75% Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance	Skilled Nursing Facility Co-insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							Out-of-pocket limit $[4140]; paid at 100% after limit reached	Out-of-pocket limit $[2070]; paid at 100% after limit reached		

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $[1860] deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

PREMIUM INFORMATION

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in this State. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

This outline shows benefits and premiums of policies sold for effective dates on or after June 1, 2010. Policies sold for effective dates prior to June 1, 2010, have different benefits and premiums. Plans E, H, I, and J are no longer available for sale. [The last sentence of this paragraph shall not appear after June 1, 2011.]

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[Insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

[Include for each plan prominently identified in the cover page a chart showing the services, Medicare payments, plan payments and insured payments, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this subrule. An issuer may use additional benefit plan descriptions on these charts pursuant to subrule 37.10(4).]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the commissioner.]

PLAN A
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$0	$[992] (Part A deductible)
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	$0	Up to $[124] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN B
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	$0	Up to $[124] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN C
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN D
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN F or HIGH DEDUCTIBLE PLAN F
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

***Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$[131] (Part B deductible)	$0
Remainder of Medicare-Approved Amounts	80%	20%	$0

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

***Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	[AFTER YOU PAY $[1860] DEDUCTIBLE,**] PLAN PAYS	[IN ADDITION TO $[1860] DEDUCTIBLE,**] YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

[**This high deductible plan pays the same benefits as Plan F after you have paid a calendar year $[1860] deductible. Benefits from the high deductible Plan F will not begin until out-of-pocket expenses are $[1860]. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.]

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN G
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	100%	0%
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN K
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[496] (50% of Part A deductible)	$[496] (50% of Part A deductible)♦
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[62] a day	Up to $[62] a day ♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	50%	50%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	50% of copayment/ coinsurance	50% of Medicare copayment/ coinsurance♦

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible)**** ♦
Preventive Benefits for Medicare-Covered Services	Generally 75% or more of Medicare-Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[4140])*****
BLOOD			
First 3 pints	$0	50%	50%♦
Next $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible)**** ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 10%	Generally 10% ♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

***** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[4140] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	80%	10%	10%♦

*You will pay half the cost sharing of some covered services until you reach the annual out-of-pocket maximum of $[4000] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual maximum, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN L
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOSPITALIZATION** Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[744] (75% of Part A deductible)	$[248] (25% of Part A deductible)♦
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0***
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE** You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[93] a day	Up to $[31] a day♦
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	75%	25%♦
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	75% of copayment/ coinsurance	25% of copayment/ coinsurance♦

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

** A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

*** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible)**** ♦
Preventive Benefits for Medicare-Covered Services	Generally 75% or more of Medicare-Approved Amounts	Remainder of Medicare-Approved Amounts	All costs above Medicare-Approved Amounts
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5% ♦
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $[2070])*****
BLOOD			
First 3 pints	$0	75%	25%♦
Next $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 15%	Generally 5%♦
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

***** This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $[2070] per year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY*
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts****	$0	$0	$[131] (Part B deductible) ♦
Remainder of Medicare-Approved Amounts	80%	15%	5%♦

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $[2070] each calendar year. The amounts that count toward your annual limit are noted with diamonds (♦) in the chart above. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.

**** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN M
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[496] (50% of Part A deductible)	$[496] (50% of Part A deductible)
61st through 90th day	All but $[248] a day	$[496] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	0%
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

PLAN N
MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[992]	$[992] (Part A deductible)	$0
61st through 90th day	All but $[248] a day	$[248] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[496] a day	$[496] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare eligible expenses	$0**
—Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $[124] a day	Up to $[124] a day	$0**
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/ coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Balance, other than up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $[20] per office visit and up to $[50] per emergency room visit. The copayment of up to $[50] is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved Amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES— TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment First $[131] of Medicare-Approved Amounts***	$0	$0	$[131] (Part B deductible)
Remainder of Medicare-Approved Amounts	80%	20%	$0

*** Once you have been billed $[131] of Medicare-approved amounts for covered services, your Part B deductible will have been met for the calendar year.

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

37.17(5) *Notice regarding policies or certificates which are not Medicare supplement policies.*

a. Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act (42 U.S.C. Section 1395 et seq.), disability income policy, or other policy identified in 191—37.2(514D) issued for delivery in this state to persons eligible for Medicare shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds. The notice shall be in no less than 12-point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company."

b. Applications provided to persons eligible for Medicare for the health insurance policies or certificates described in 37.17(4)*"a"* shall disclose, using the applicable statement in Appendix C, the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as a part of, or together with, the application for the policy or certificate.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.18(514D) Requirements for application forms and replacement coverage.

37.18(1) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

a. Statements.

(1) You do not need more than one Medicare supplement policy.

(2) If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(4) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your

policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(5) If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

(6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

b. Questions.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

(Please mark Yes or No below with an "X".)

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?

Yes____No____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes____No____

(c) If yes, what is the effective date? _____

(2) Are you covered for medical assistance through the state Medicaid program?

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

Yes____No____

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy?

Yes____No____

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

Yes____No____

(3) (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

Yes____No____

(c) Was this your first time in this type of Medicare plan?

Yes____No____

(d) Did you drop a Medicare supplement policy to enroll in this plan?

Yes____No____

(4) (a) Do you have another Medicare supplement policy in force?

Yes____No____

(b) If so, with what company, and what plan do you have [optional for Direct Mailers]? _____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes____No____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes____No____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

37.18(2) Agents shall list any other health insurance policies they have sold to the applicant.

a. List policies sold which are still in force.

b. List policies sold in the past five years which are no longer in force.

37.18(3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

37.18(4) Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage. One copy of such notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

37.18(5) The notice required by subrule 37.18(4) for an issuer shall be provided in substantially the following form in no less than 12-point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE
OR MEDICARE ADVANTAGE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]: I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement

coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
____ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. [optional only for Direct Mailers]
____ Other. (Please specify.)_____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Agent, Broker or Other Representative)*
[Typed Name and Address of Issuer, Agent or Broker]

_____
(Applicant's Signature)

_____
(Date)

*Signature not required for direct response sales.

37.18(6) Statements 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.19(514D) Standards for marketing.

37.19(1) An issuer, directly or through its producers, shall:

a. Establish marketing procedures to ensure that any comparison of policies by its agent or other producers will be fair and accurate.

b. Establish marketing procedures to ensure excessive insurance is not sold or issued.

c. Display prominently by type, stamp or other appropriate means, on the first page of the policy, the following:

"Notice to buyer: This policy may not cover all of your medical expenses."

d. Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance.

e. Establish auditable procedures for certifying compliance with this subrule.

f. At solicitation, provide written notice to the prospective policyholder or certificate holder of the name, address, and telephone number of the senior insurance counseling program approved in Iowa by the commissioner of insurance. The written notice shall be in a form prescribed by the commissioner.

37.19(2) In addition to the practices prohibited in Iowa Code chapter 507B, the following acts and practices are prohibited:

a. Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

b. High-pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

c. Cold-lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

37.19(3) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this chapter.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.20(514D) Appropriateness of recommended purchase and excessive insurance.

37.20(1) In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

37.20(2) Any sale of a Medicare supplement policy or certificate that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

37.20(3) An issuer shall not issue a Medicare supplement policy or certificate to an individual enrolled in Medicare Part C unless the effective date of the coverage is after the termination date of the individual's Part C coverage.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.21(514D) Reporting of multiple policies.

37.21(1) On or before March 1 of each year, an issuer shall report the following information for every individual resident of this state for which the issuer has in force more than one Medicare supplement policy or certificate:

a. Policy and certificate number, and

b. Date of issuance.

37.21(2) The items set forth above must be grouped by individual policyholder.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.22(514D) Prohibition against preexisting conditions, waiting periods, elimination periods and probationary periods in replacement policies or certificates.

37.22(1) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy.

37.22(2) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any

time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.23(514D) Prohibition against use of genetic information and requests for genetic testing. This rule applies to all policies with policy years beginning on or after May 21, 2009.

37.23(1) For the purposes of this rule only, the following definitions shall apply:

"Family member" means, with respect to an individual, any other individual who is a first-degree, second-degree, third-degree, or fourth-degree relative of such individual.

"Genetic information" means, with respect to any individual, information about such individual's genetic tests, the genetic tests of family members of such individual, and the manifestation of a disease or disorder in family members of such individual. "Genetic information" includes, with respect to any individual, any request for, or receipt of, genetic services, or participation in clinical research which includes genetic services, by such individual or any family member of such individual. Any reference to genetic information concerning an individual or family member of an individual who is a pregnant woman includes genetic information of any fetus carried by such pregnant woman or, with respect to an individual or family member utilizing reproductive technology, includes genetic information of any embryo legally held by an individual or family member. The term "genetic information" does not include information about the sex or age of any individual.

"Genetic services" means a genetic test, genetic counseling (including obtaining, interpreting, or assessing genetic information), or genetic education.

"Genetic test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean:

1. An analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or
2. An analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

"Issuer of a Medicare supplement policy or certificate" means the same as "issuer" as defined in rule 191—37.3(514D) and includes third-party administrator, or other person acting for or on behalf of such issuer.

"Underwriting purposes" means:

1. Rules for or determination of eligibility (including enrollment and continued eligibility) for benefits under the policy;
2. The computation of premium or contribution amounts under the policy;
3. The application of any preexisting condition exclusion under the policy; and
4. Other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

37.23(2) An issuer of a Medicare supplement policy or certificate:

a. Shall not deny or condition the issuance or effectiveness of the policy or certificate (including the imposition of any exclusion of benefits under the policy based on a preexisting condition) of an individual on the basis of the genetic information with respect to such individual; and

b. Shall not discriminate in the pricing of the policy or certificate (including the adjustment of premium rates) of an individual on the basis of the genetic information with respect to such individual.

37.23(3) Nothing in subrule 37.23(2) shall be construed to limit the ability of an issuer, to the extent otherwise permitted by law, from:

a. Denying or conditioning the issuance or effectiveness of the policy or certificate or increasing the premium for a group based on the manifestation of a disease or disorder of an insured or applicant; or

b. Increasing the premium for any policy issued to an individual based on the manifestation of a disease or disorder of another individual who is covered under the policy. In such case, the manifestation of a disease or disorder in one individual cannot also be used as genetic information about other group members and to further increase the premium for the group.

37.23(4) An issuer of a Medicare supplement policy or certificate shall not request or require an individual or a family member of such individual to undergo a genetic test.

37.23(5) Subrule 37.23(4) shall not be construed to preclude an issuer of a Medicare supplement policy or certificate from obtaining and using the results of a genetic test in making a determination regarding payment (as defined for the purposes of applying the regulations promulgated under Part C of Title XI and Section 264 of the Health Insurance Portability and Accountability Act of 1996, as may be revised from time to time) and consistent with subrule 37.23(2).

37.23(6) For purposes of carrying out subrule 37.23(5), an issuer of a Medicare supplement policy or certificate may request only the minimum amount of information necessary to accomplish the intended purpose.

37.23(7) Notwithstanding subrule 37.23(4), an issuer of a Medicare supplement policy may request, but not require, that an individual or a family member of such individual undergo a genetic test if each of the following conditions is met:

a. The request is made pursuant to research that complies with Part 46 of Title 45, Code of Federal Regulations, or equivalent federal regulations, and any applicable state or local law or regulations for the protection of human subjects in research.

b. The issuer clearly indicates to each individual, or in the case of a minor child, to the legal guardian of such child, to whom the request is made that:

(1) Compliance with the request is voluntary; and

(2) Noncompliance will have no effect on enrollment status or premium or contribution amounts.

c. No genetic information collected or acquired under this subrule shall be used for underwriting, determination of eligibility to enroll or maintain enrollment status, premium rates, or the issuance, renewal, or replacement of a policy or certificate.

d. The issuer notifies the Secretary of the U.S. Department of Health and Human Services in writing that the issuer is conducting activities pursuant to the exception provided for under this subrule, including a description of the activities conducted.

e. The issuer complies with such other conditions as the Secretary of the U.S. Department of Health and Human Services may by regulation require for activities conducted under this subrule.

37.23(8) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information for underwriting purposes.

37.23(9) An issuer of a Medicare supplement policy or certificate shall not request, require, or purchase genetic information with respect to any individual prior to such individual's enrollment under the policy in connection with such enrollment.

37.23(10) If an issuer of a Medicare supplement policy or certificate obtains genetic information incidental to the requesting, requiring, or purchasing of other information concerning any individual, such request, requirement, or purchase shall not be considered a violation of subrule 37.23(9) if such request, requirement, or purchase is not in violation of subrule 37.23(8).

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.24(514D) Prohibition against using SHIIP prepared materials The Senior Health Insurance Information Program (SHIIP) may prepare a consumer Medicare supplement insurance premium guide and benefits comparison guide. This guide and the SHIIP name or logo shall not be used in the solicitation or sale of health insurance products. Violation of this provision shall be deemed an unfair trade practice under Iowa Code chapter 507B.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.25(514D) Guaranteed issue for eligible persons.

37.25(1) Eligible persons are those individuals described in subrule 37.25(2) who seek to enroll under the policy during the period specified in subrule 37.25(3) and who submit evidence of the date of termination, disenrollment, or Medicare Part D enrollment with the application for a Medicare supplement policy.

With respect to eligible persons, an issuer shall not deny or condition the issuance or effectiveness of a Medicare supplement policy described in subrule 37.25(5) that is offered and is available for issuance to

new enrollees by issuer, shall not discriminate in the pricing of such Medicare supplement policy because of health status, claims experience, receipt of health care, or medical condition, and shall not impose an exclusion of benefits based on a preexisting condition under such Medicare supplement policy.

37.25(2) An eligible person is an individual described in any of the following paragraphs:

a. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement benefits under Medicare and the plan terminates or the plan ceases to provide some or all such supplemental health benefits to the individual;

b. The individual is enrolled with a Medicare Advantage organization under Medicare Advantage under Part C of Medicare and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act and circumstances exist similar to those described below that would permit discontinuance of the individual's enrollment with such a provider if such individual were enrolled in Medicare Advantage:

(1) The certification of the organization or plan under this part has been terminated; or

(2) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or

(3) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in Section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under Section 1856), or the plan is terminated for all individuals within a residence area; or

(4) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

1. The organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

2. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(5) The individual meets such other exceptional conditions as the Secretary may provide;

c. The individual is enrolled with:

(1) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); or

(2) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or

(3) An organization operating under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(4) An organization under Medicare Select policy; and

(5) The enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph 37.25(2)*"b"*;

d. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(1) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or

(2) The issuer of the policy substantially violated a material provision of the policy; or

(3) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

e. The individual was enrolled under a Medicare supplement policy and terminated enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under Medicare Advantage under Part C of Medicare, any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under Section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment under 37.25(2)*"e"* was terminated by the enrollee during any period

within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act); or

f. The individual upon first becoming enrolled for benefits under Part B of Medicare at age 65 or older enrolls in Medicare Advantage under Part C of Medicare or with a PACE provider under Section 1894 of the Social Security Act and disenrolls from the plan or program by no later than 12 months after the effective date of enrollment.

g. The individual enrolls in a Medicare Part D plan during the initial enrollment period, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in paragraph 37.25(5)*"e."*

37.25(3) Guaranteed issue time periods.

a. In the case of an individual described in paragraph 37.25(2)*"a,"* the guaranteed issue period begins on the later of: (1) the date the individual receives a notice of termination or cessation of some or all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (2) the date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

b. In the case of an individual described in paragraph 37.25(2)*"b," "c," "e"* or *"f"* whose enrollment is terminated involuntarily, the guaranteed issue period begins on the date that the individual receives a notice of termination and ends 63 days after the date the applicable coverage is terminated.

c. In the case of an individual described in subparagraph 37.25(2)*"d"*(1), the guaranteed issue period begins on the earlier of (1) the date that the individual receives a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice, if any, and (2) the date that the applicable coverage is terminated, and ends on the date that is 63 days after the date the coverage is terminated.

d. In the case of an individual described in paragraph 37.25(2)*"b,"* subparagraph 37.25(2)*"d"*(2), subparagraph 37.25(2)*"e"*(2), paragraph 37.25(2)*"e"* or paragraph 37.25(2)*"f"* who disenrolls voluntarily, the guaranteed issue period begins on the date that is 60 days before the effective date of the disenrollment and ends on the date that is 63 days after the effective date.

e. In the case of an individual described in paragraph 37.25(2)*"g,"* the guaranteed issue period begins on the date the individual receives notice pursuant to Section 1882(v)(2)(B) of the Social Security Act from the Medicare supplement issuer during the 60-day period immediately preceding the initial Part D enrollment period and ends on the date that is 63 days after the effective date of the individual's coverage under Medicare Part D; and

f. In the case of an individual described in subrule 37.25(2) but not described in the preceding paragraphs 37.25(3)*"a"* to *"e,"* the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is 63 days after the effective date.

37.25(4) Extended Medigap access for interrupted trial periods.

a. In the case of an individual described in paragraph 37.25(2)*"e"* (or deemed to be so described pursuant to paragraph 37.25(4)*"a"*) whose enrollment with an organization or provider described in paragraph 37.25(2)*"e"* is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.25(2)*"e."*

b. In the case of an individual described in paragraph 37.25(2)*"f"* (or deemed to be so described pursuant to paragraph 37.25(4)*"b"*) whose enrollment with a plan or in a program described in paragraph 37.25(2)*"f"* is involuntarily terminated within the first 12 months of enrollment and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment as described in paragraph 37.25(2)*"f."*

c. For purposes of paragraphs 37.25(2)*"e"* and *"f,"* no enrollment of an individual with an organization or provider described in paragraph 37.25(2)*"e,"* or with a plan or in a program described in paragraph 37.25(2)*"f,"* may be deemed to be an initial enrollment under paragraph 37.25(4)*"c"*

after the two-year period beginning on the date on which the individual first enrolled with such an organization, provider, plan or program.

37.25(5) Products to which eligible persons are entitled. The Medicare supplement policy to which eligible persons are entitled under:

a. Subrule 37.25(2), paragraphs *"a," "b," "c,"* and *"d,"* is a Medicare supplement policy which has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.

b. Subject to paragraph 37.25(5)*"c,"* paragraph 37.25(2)*"e"* is the same Medicare supplement policy in which the individual was most recently previously enrolled if available from the same issuer, or, if not so available, a policy described in paragraph 37.25(5)*"a."*

c. After December 31, 2005, if the individual was most recently enrolled in a Medicare supplement policy with an outpatient prescription drug benefit, a Medicare supplement policy described in this paragraph is:

(1) The policy available from the same issuer but modified to remove outpatient prescription drug coverage; or

(2) At the election of the policyholder, an A, B, C, F (including F with a high deductible), K or L policy that is offered by any issuer.

d. Paragraph 37.25(2)*"f"* shall include any Medicare supplement policy offered by any issuer.

e. Paragraph 37.25(2)*"g"* is a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F (including F with a high deductible), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

37.25(6) Notification of provisions.

a. At the time of an event described in subrule 37.25(2) because of which an individual loses coverage or benefits due to the termination or change of a contract or agreement, policy, or plan, the organization that terminates or changes the contract or agreement, the issuer terminating or changing the policy, or the administrator of the plan being terminated or changed, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.25(1). Such notice shall be communicated contemporaneously with the notification of termination.

b. At the time of an event described in subrule 37.25(2) because of which an individual ceases enrollment under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, regardless of the basis for the cessation of enrollment, the issuer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the individual's rights under this rule and of the obligations of issuers of Medicare supplement policies under subrule 37.25(1). Such notice shall be communicated within ten working days of the issuer receiving notification of the disenrollment.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.26(514D) Severability. If any provisions of this chapter or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the chapter and the application of such provision to other persons or circumstances shall not be affected thereby.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.27 to **37.49** Reserved.

DIVISION II
MEDICARE SUPPLEMENT ADVERTISING

191—37.50(507B,514D) Purpose. The purpose of the rules in this division is to provide prospective purchasers with clear and unambiguous statements in the advertisement of Medicare supplement insurance and to assure the clear and truthful disclosure of the benefits, limitations and exclusions of policies sold as Medicare supplement insurance. This purpose is intended to be accomplished by the establishment of guidelines and permissible and impermissible standards of conduct in the advertising

of Medicare supplement insurance in a manner which prevents unfair, deceptive and misleading advertising and which is conducive to accurate presentation and description to the insurance-buying public through the advertising media and material used by insurance producers and companies.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.51(507B,514D) Applicability.

37.51(1) "Insurer," for the purpose of these rules, shall include any individual, corporation, association, partnership, reciprocal exchange, inter-insurer, Lloyd's, fraternal benefit society, health maintenance organization, hospital service corporation, medical service corporation, prepaid health plan and any other legal entity which is defined as an "issuer" in rule 191—37.3(514D) and is engaged in the advertisement of itself, or Medicare supplement insurance.

These rules shall apply to any "advertisement" of Medicare supplement insurance, as that term is defined in rule 191—37.52(507B,514D), unless otherwise specified in Division II of this chapter, that the insurer or producer knows or reasonably should know is intended for presentation, distribution or dissemination in this state when the presentation, distribution or dissemination is made either directly or indirectly by or on behalf of an insurer or producer, as those terms are defined in rule 191—15.2(507B).

37.51(2) Advertising materials that are reproduced in quantity shall be identified by form numbers or other identifying means. The identification shall be sufficient to distinguish an advertisement from any other advertising materials, policies, applications or other materials used by the insurer.

37.51(3) The requirements of Iowa Code chapter 507B and 191—Chapter 15 also shall apply to insurers and producers to which 191—Chapter 37, Division II, applies, unless specifically exempted therein.
[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.52(507B,514D) Definitions. In addition to the definitions in Iowa Code section 507B.2 and rule 191—15.2(507B), the following definitions shall apply to 191—Chapter 37, Division II. When there is a definition for a term in this rule and also in Iowa Code section 507B.2 or rule 191—15.2(507B), the definition in this rule shall take precedence.

"Advertisement" includes:

1. The definition of "advertisement" in rule 191—15.2(507B).
2. Advertising material included with a policy when the policy is delivered and material used in the solicitation of renewals and reinstatements.
3. The definition of "advertisement" does not include:

- Items excluded in the definition of "advertisement" in rule 191—15.2(507B).
- Correspondence between a prospective group or blanket policyholder and an insurer in the course of negotiating a group or blanket contract.
- Court-approved material ordered by a court to be disseminated to policyholders.

"Certificate" means any certificate issued under a group Medicare supplement policy, which certificate has been delivered or issued for delivery in this state.

"Institutional advertisement" means an advertisement having as its sole purpose the promotion of the reader's, viewer's or listener's interest in the concept of Medicare supplement insurance, or the promotion of the insurer as a seller of Medicare supplement insurance.

"Lead-generating device" means any communication directed to the public that, regardless of form, content or stated purpose, is intended to result in the compilation or qualification of a list containing names and other personal information to be used to solicit residents of this state for the purchase of Medicare supplement insurance.

"Limitation" means any provision other than an exception or a reduction that restricts coverage under the policy.

"Medicare" means "The Health Insurance for the Aged Act, Title XVIII of The Social Security Amendments of 1965 as Then Constituted or Later Amended," or Title I, Part I, of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America, and also known as the "Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

"Medicare supplement insurance" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service associations or health maintenance organizations that is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

"Person" means a natural person, association, organization, partnership, trust, group, discretionary group, corporation or any other entity.

"Reduction" means any provision that reduces the amount of the benefit; a risk of loss is assumed but payment upon the occurrence of the loss is limited to some amount or period less than would be otherwise payable had the reduction not been used.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.53(507B,514D) Form and content of advertisements. An insurer must clearly identify its Medicare supplement insurance policy as an insurance policy. A policy trade name must be followed by the words "Insurance Policy" or similar words clearly identifying the fact that an insurance policy or health benefits product (in the case of health maintenance organizations, prepaid health plans and other direct service organizations) is being offered.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.54(507B,514D) Testimonials or endorsements by third parties. In addition to complying with 191—subrule 15.3(7), when a testimonial refers to benefits received under a Medicare supplement insurance policy, the insurer shall retain the specific claim data, including claim number, date of loss, and other pertinent information, for a period of four years or until the filing of the next regular report of examination of the insurer, whichever is the longer period of time. The use of testimonials that do not correctly reflect the present practices of the insurer or that are not applicable to the policy or benefit being advertised is not permissible.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.55(507B,514D) Use of statistics; jurisdictional licensing; status of insurer. Advertisements shall be in compliance with 191—subrule 15.3(5) and with the following:

37.55(1) An advertisement shall specifically identify the Medicare supplement insurance policy to which statistics relate and, where statistics are given which are applicable to a different policy, the advertisement shall state clearly that the data do not relate to the policy being advertised.

37.55(2) An advertisement that is intended to be seen or heard beyond the limits of the jurisdiction in which the insurer is licensed shall not imply licensing beyond those limits.

37.55(3) An advertisement shall not create the impression directly or indirectly that the insurer, the insurer's financial condition or status, the insurer's payment of its claims, or the merits, desirability or advisability of the insurer's policy forms or kinds of plans of insurance are approved, endorsed or accredited by any division or agency of this state or of the United States government.

37.55(4) An advertisement shall not imply that approval, endorsement or accreditation of policy forms or advertising has been granted by any division or agency of this state or of the United States government. "Approval" of either policy forms or advertising shall not be used by an insurer to imply or state that a governmental agency has endorsed or recommended the insurer, its policies, its advertising or its financial condition.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.56(507B,514D) Identity of insurer. Advertisements shall be in compliance with 191—subrule 15.3(9) and with the following:

37.56(1) Advertisements, stationery or envelopes that employ words, letters, initials, symbols or other devices are not permitted if they are so similar to those used by governmental agencies or other insurers that they may lead the public to believe:

a. The advertised coverages are somehow provided by or are endorsed by the governmental agencies or the other insurers;

b. The advertiser is the same as, is connected with or is endorsed by the governmental agencies or the other insurers.

37.56(2) No advertisement shall use the name of a state or political subdivision thereof in a policy name or description.

37.56(3) No advertisement in the form of envelopes or stationery of any kind may use any name, service mark, slogan, symbol or any device in such a manner that implies that the insurer or the policy advertised, or that any producer who may call upon the consumer in response to the advertisement, is connected with a governmental agency, such as the Social Security Administration.

37.56(4) No advertisement may incorporate the word "Medicare" in the title of the plan or policy being advertised unless, wherever it appears, the word is qualified by language differentiating the plan or policy from Medicare. Such an advertisement, however, shall not use the phrase "_____ Medicare Department of the _____ Insurance Company," or language of similar import.

37.56(5) No advertisement shall be used that fails to include a disclaimer to the effect of "Not connected with or endorsed by the U.S. government or the federal Medicare program."

37.56(6) No advertisement may imply that the reader may lose a right, privilege or benefit under federal, state or local law if the reader fails to respond to the advertisement.

37.56(7) No insurer may use, in the trade name of its insurance policy, any terminology or words so similar to the name of a governmental agency or governmental program as to have the tendency to confuse, deceive or mislead the prospective purchaser.

37.56(8) All advertisements used by producers or solicitors of an insurer shall have prior written approval of the insurer before the advertisements may be used.

37.56(9) A producer who makes contact with a consumer as a result of acquiring that consumer's name from a lead-generating device shall disclose that fact in the initial contact with the consumer.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.57(507B,514D) Introductory, initial or special offers.

37.57(1) Enrollment periods.

a. An advertisement of an individual policy shall not directly or by implication represent that a contract or combination of contracts is an introductory, initial or special offer, or that applicants will receive substantial advantages not available at a later date, or that the offer is available only to a specified group of individuals, unless such representation is true. An advertisement shall not contain phrases describing an enrollment period as "special," "limited," or similar words or phrases when the insurer uses such enrollment periods as the usual method of advertising Medicare supplement insurance.

b. An enrollment period during which a particular insurance product may be purchased on an individual basis shall not be offered within this state unless there has been a lapse of not less than six months between the close of the immediately preceding enrollment period for the same product and the opening of the new enrollment period. The advertisement shall indicate the date by which the applicant must mail the application, which shall be not fewer than 10 days and not more than 40 days from the date that the enrollment period is advertised for the first time. This rule applies to all advertising media, e.g., mail, newspapers, electronic mail, Web sites, radio, television, magazines and periodicals, used by any one insurer. This rule is not applicable to solicitations of employees or members of a particular group or association that otherwise would be eligible for group, blanket or franchise insurance. The phrase "any one insurer" in this paragraph includes all the affiliated companies of a group of insurance companies under common management or control. The phrase "a particular insurance product" in this paragraph means an insurance policy that provides benefits substantially different from those contained in any other policy. Different terms of renewability, an increase or decrease in the dollar amounts of benefits, or an increase or decrease in any elimination period or waiting period from those available during an enrollment period for another policy shall not be sufficient to constitute the product's being offered as a different product eligible for concurrent or overlapping enrollment periods.

c. This rule prohibits any statement or implication to the effect that only a specific number of policies will be sold, or that a time is fixed for the discontinuance of the sale of the particular policy advertised because of special advantages available in the policy, unless either is true.

37.57(2) An advertisement shall not offer a policy that utilizes a reduced initial premium rate in a manner that overemphasizes the availability and the amount of the initial reduced premium. When an insurer charges an initial premium that differs in amount from the amount of the renewal premium payable on the same mode, the advertisement shall not display the amount of the reduced initial premium either more frequently or more prominently than the renewal premium, and both the initial reduced premium and the renewal premium shall be stated in juxtaposition in each portion of the advertisement where the initial reduced premium appears. The term "juxtaposition" means side by side or immediately above or below.

37.57(3) Special awards, such as a "safe driver's award," shall not be used in connection with advertisements of Medicare supplement insurance.

37.57(4) An invitation to inquire, which means an advertisement having as its objective the creation of a desire to inquire further about Medicare supplement insurance that is limited to a brief description of coverage, shall contain a provision in the following or substantially similar form:

"This policy has [exclusions] [limitations] [reductions of benefits] [terms under which the policy may be continued in force or discontinued]. For costs and complete details of the coverage, call [or write] your insurance producer or the company [whichever is applicable]."

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.58(507B,514D) Enforcement procedures—certificate of compliance. Each insurer required to file an annual statement which is now or which hereafter becomes subject to the provisions of these rules must file with the insurance division, with the insurer's annual statement, a certificate of compliance executed by an authorized officer of the insurer wherein it is stated that, to the best of the authorized officer's knowledge, information and belief, the advertisements that were disseminated by the insurer during the preceding statement year complied with or were made to comply in all respects with the provisions of these rules and the laws of this state as implemented and interpreted by these rules.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

191—37.59(507B,514D) Filing for prior review. The commissioner may, at the commissioner's discretion, require the filing with the insurance division, for review prior to use, of any Medicare supplement insurance advertising material.

[**ARC 7964B**, IAB 7/15/09, effective 8/19/09]

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1]_____ SMSBP[2]_____
For the State of_____ Company Name _____
NAIC Group Code_____ NAIC Company Code_____
Address_____ Person Completing This Exhibit_____
Title_____ Telephone Number_____

Line		(a) Earned Premium[3]	(b) Incurred Claims[4]
1.	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues[5]		
	c. Net (for reporting purposes = 1a - 1b)		
2.	Past Years' Experience (all policy years)		
3.	Total Experience (Net Current Year + Past Year)		

4.	Refunds Last Year (excluding interest)	
5.	Previous Since Inception (excluding interest)	
6.	Refunds Since Inception (excluding interest)	
7.	Benchmark Ratio Since Inception (see worksheet for Ratio 1)	
8.	Experienced Ratio Since Inception (Ratio 2) Total Actual Incurred Claims (line 3, col. b) Total Earned Prem. (line 3, col. a) - Refunds Since Inception (line 6)	
9.	Life Years Exposed Since Inception If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.	
10.	Tolerance Permitted (obtained from credibility table)	

Medicare Supplement Credibility Table

Life Years Exposed	
Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%
If less than 500, no credibility.	

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.
[3] Includes Modal Loadings and Fees Charged.
[4] Excludes Active Life Reserves.
[5] This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios."

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____
For the State of _____ Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____ Person Completing This Exhibit _____
Title _____ Telephone Number _____

11.	Adjustment to Incurred Claims for Credibility Ratio 3 = Ratio 2 + Tolerance	

If Ratio 3 is more than Benchmark Ratio (Ratio 1), a refund or credit to premium is not required. If Ratio 3 is less than the Benchmark Ratio, then proceed.

12.	Adjusted Incurred Claims [Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6)] × Ratio 3 (line 11)	
13.	Refund = Total Earned Premiums (line 3, col. a) - Refunds Since Inception (line 6) - [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]	

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund or credit against premiums to be used must be attached to this form.

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name (Please type.)

_____
Title (Please type.)

_____
Date

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.
[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b) × (c)	Cumulative Loss Ratio	(d) × (e)	Factor	(b) × (g)	Cumulative Loss Ratio	(h) × (i)	Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.80
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15+[6]		4.175		0.567		8.684		0.838		0.89
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

[6] To include the earned premium for all years prior to as well as the 15th year prior to the current year.

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES
FOR CALENDAR YEAR _____

TYPE[1] _____ SMSBP[2] _____

For the State of _____ Company Name _____

NAIC Group Code _____ NAIC Company Code _____

Address _____ Person Completing This Exhibit _____

Title _____ Telephone Number _____

(a)[3]	(b)[4]	(c)	(d)	(e)	(f)	(g)	(h)	(i)	(j)	(o)[5]
Year	Earned Premium	Factor	(b) × (c)	Cumulative Loss Ratio	(d) × (e)	Factor	(b) × (g)	Cumulative Loss Ratio	(h) × (i)	Policy Year Loss Ratio
1		2.770		0.442		0.000		0.000		0.40
2		4.175		0.493		0.000		0.000		0.55
3		4.175		0.493		1.194		0.659		0.65
4		4.175		0.493		2.245		0.669		0.67
5		4.175		0.493		3.170		0.678		0.69
6		4.175		0.493		3.998		0.686		0.71
7		4.175		0.493		4.754		0.695		0.73
8		4.175		0.493		5.445		0.702		0.75
9		4.175		0.493		6.075		0.708		0.76
10		4.175		0.493		6.650		0.713		0.76
11		4.175		0.493		7.176		0.717		0.76
12		4.175		0.493		7.655		0.720		0.77
13		4.175		0.493		8.093		0.723		0.77
14		4.175		0.493		8.493		0.725		0.77
15+[6]		4.175		0.493		8.684		0.725		0.77
Total:			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n)/(k + m): _____

[1] Individual, Group, Individual Medicare Select, or Group Medicare Select only.

[2] "SMSBP" = Standardized Medicare Supplement Benefit Plan – Use "P" for prestandardized plans.

[3] Year 1 is the current calendar year - 1. Year 2 is the current calendar year - 2 (etc.). (Example: If the current year is 1991, then: Year 1 is 1990; Year 2 is 1989, etc.)

[4] For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

[5] These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes.

[6] To include the earned premium for all years prior to as well as the 15th year prior to the current year.

Appendix B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date

APPENDIX C
DISCLOSURE STATEMENTS
Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare

1. Section 1882(d) of the federal Social Security Act [42 U.S.C. 1395ss] prohibits the sale of a health insurance policy (the term policy includes certificate) to Medicare beneficiaries that duplicates Medicare benefits unless it will pay benefits without regard to a beneficiary's other health coverage and it includes the prescribed disclosure statement on or together with the application for the policy.

2. All types of health insurance policies that duplicate Medicare shall include one of the attached disclosure statements, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from the attached statements in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

3. State and federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement policy.

4. Property/casualty and life insurance policies are not considered health insurance.

5. Disability income policies are not considered to provide benefits that duplicate Medicare.

6. Long-term care insurance policies that coordinate with Medicare and other health insurance are not considered to provide benefits that duplicate Medicare.

7. The federal law does not preempt state laws that are more stringent than the federal requirements.

8. The federal law does not preempt existing state form filing requirements.

9. Section 1882 of the federal Social Security Act was amended in Subsection (d)(3)(A) to allow for alternative disclosure statements. The disclosure statements already in Appendix C remain. Carriers may use either disclosure statement with the requisite insurance product. However, carriers should use either the original disclosure statements or the alternative disclosure statements and not use both simultaneously.

[Original disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Hospice
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any expenses or services covered by the policy are also covered by Medicare; or
- It pays the fixed dollar amount stated in the policy and Medicare covers the same event

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Original disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- The benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for expenses incurred for an accidental injury only.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits for specified limited services.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits under this policy.

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that reimburse expenses incurred for specified diseases or other specified impairments. This includes expense-incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy. Medicare generally pays for most or all of these expenses.

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for policies that provide benefits upon both an expense-incurred and fixed indemnity basis.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice care
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

[Alternative disclosure statement for other health insurance policies not specifically identified in the preceding statements.]

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- [Outpatient Prescription Drugs if you are enrolled in Medicare Part D]
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in all health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or your state health insurance assistance program (SHIP).

Drafting Note: Insurers insert reference to: Outpatient Prescription Drugs and state health insurance assistance program (SHIP) above when new notices need to be printed after December 31, 2005.

These rules are intended to implement Iowa Code chapters 507B and 514D.

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[1] Effective date of 12/31/81 delayed 70 days by Administrative Rules Review Committee.

CHAPTER 14
SELLER PROPERTY CONDITION DISCLOSURE
[Prior to 9/4/02, see 193E—Ch 1]

193E—14.1(543B) Property condition disclosure requirement. The requirements of this chapter shall apply to transfers of real estate subject to Iowa Code chapter 558A. For purposes of this chapter, "transfer" means the transfer or conveyance of real estate by sale, exchange, real estate contract, or any other method by which real estate and improvements are purchased, including rental or lease agreements which contain any option to purchase, if the property includes at least one but no more than four dwelling units unless the transfer is exempted by Iowa Code section 558A.1(4).

14.1(1) *Additional disclosure.* Nothing in this rule is intended to prevent any additional disclosure or to relieve the parties or agents in the transaction from making any disclosure otherwise required by law or contract.

14.1(2) *Licensee responsibilities to seller.* At the time a licensee obtains a listing, the listing licensee shall obtain a completed disclosure signed and dated by each seller represented by the licensee.

a. A licensee representing a seller shall deliver the executed statement to a potential buyer, a potential buyer's agent, or any other third party who may be representing a potential buyer, prior to the seller's making a written offer to sell or the seller's accepting a written offer to buy.

b. The licensee representing a seller shall attempt to obtain the buyer's signature and date of signature on the statement and shall provide the seller and the buyer with fully executed copies of the disclosure and maintain a copy of the written acknowledgment in the transaction file. If the licensee is unable to obtain the buyer's signature, the licensee shall obtain other documentation establishing delivery of the disclosure and maintain the written documentation in the transaction file.

c. If the transaction closes, the listing broker shall maintain the completed disclosure statement for a minimum of five years.

d. The executed disclosure statement shall be delivered to the buyer(s) by either personal delivery or by certified or registered mail. If there is more than one buyer, any one buyer may accept delivery of the executed statement.

14.1(3) *Licensee responsibilities to buyer.* A licensee representing a buyer in a transfer shall notify the buyer of the seller's obligation to deliver the property disclosure statement.

a. If the disclosure statement is not delivered when required, the licensee shall notify the buyer that the buyer may revoke or withdraw the offer.

b. If a buyer elects to revoke or withdraw the offer, the licensee shall obtain a written revocation or withdrawal from the buyer and shall deliver the revocation or withdrawal to the seller within three days following personal delivery or five days following delivery of the disclosure by mail to the buyer.

c. Following revocation or withdrawal of the offer, any earnest money deposit shall be promptly returned without liability pursuant to Iowa Code chapter 558A and rule 193E—13.4(543B).

14.1(4) *Inclusion of written reports.* A written report or opinion prepared by a person qualified to render the report or opinion may be included in a disclosure statement. A report may be prepared by, but not limited to, the following persons provided that the content of the report or opinion is within the specified area of expertise of the provider: a land surveyor licensed pursuant to Iowa Code chapter 542B; a geologist; a structural pest control operator licensed pursuant to Iowa Code section 206.6; or a qualified building contractor.

a. The seller must identify the required disclosure items which are to be satisfied by the report.

b. If the report is prepared for the specific purpose of satisfying the disclosure requirement, the preparer of the report shall specifically identify the items of the disclosure which the report is intended to satisfy.

c. A licensee representing a seller shall provide the seller with information on the proper use of reports if reports are used as part of the disclosure statement.

14.1(5) *Amended disclosure statement.* A licensee's obligations with respect to any amended disclosure statement are the same as the licensee's obligations with respect to the original disclosure

statement. A disclosure statement must be amended if information disclosed is or becomes inaccurate or misleading or is supplemented unless one of the following exceptions applies:

a. The information disclosed in conformance with Iowa Code chapter 558A is subsequently rendered inaccurate as a result of an act, occurrence, or agreement subsequent to the delivery of the disclosure statement.

b. The information disclosed is based on information of a public agency, including the state, a political subdivision of the state, or the United States.

14.1(6) *Minimum disclosure statement contents for all transfers.* All property disclosure statements, whether or not a licensee assists in the transaction, shall contain at a minimum the information required by the following sample statement. No particular language is required in the disclosure statement provided that the required disclosure items are included and the disclosure complies with Iowa Code chapter 558A. To assist real estate licensees and the public, the commission recommends use of the following sample language:

RESIDENTIAL PROPERTY SELLER DISCLOSURE STATEMENT

Property address: _____

PURPOSE:

Use this statement to disclose information as required by Iowa Code chapter 558A. This law requires certain sellers of residential property that includes at least one and no more than four dwelling units to disclose information about the property to be sold. The following disclosures are made by the seller(s) and not by any agent acting on behalf of the seller(s).

INSTRUCTIONS TO SELLER(S):

1. Seller(s) must complete this statement. Respond to all questions, or attach reports allowed by Iowa Code section 558A.4(2);
2. Disclose all known conditions materially affecting this property;
3. If an item does not apply to this property, indicate that it is not applicable **(N/A)**;
4. Please provide information in good faith and make a reasonable effort to ascertain the required information. If the required information is **unknown** or is **unavailable** following a reasonable effort, use an **approximation** of the information, or indicate that the information is **unknown (UNK)**. All **approximations** must be identified as **approximations (AP)**;
5. Additional pages may be attached as needed;
6. Keep a copy of this statement with your other important papers.

1. Basement/Foundation: Any known water or other problems? Yes [ ] No [ ]
2. Roof: Any known problems? Yes [ ] No [ ]
   Any known repairs? Yes [ ] No [ ]
   If yes, date of repairs/replacement: ____/____/____
3. Well and Pump: Any known problems? Yes [ ] No [ ]
   Any known repairs? Yes [ ] No [ ]
   If yes, date of repairs/replacement: ____/____/____
   Any known water tests? Yes [ ] No [ ]
   If yes, date of last report: ____/____/____
   and results: _____
4. Septic Tanks/Drain Fields: Any known problems? Yes [ ] No [ ]
   Location of tank: _____
   Date tank last cleaned: ____/____/____
5. Sewer System: Any known problems? Yes [ ] No [ ]
   Any known repairs? Yes [ ] No [ ]

If yes, date of repairs/replacement: ____/____/____

6. Heating System(s): Any known problems? Yes [ ] No [ ]
   Any known repairs? Yes [ ] No [ ]
   If yes, date of repairs/replacement: ____/____/____
7. Central Cooling System(s): Any known problems? Yes [ ] No [ ]
   Any known repairs? Yes [ ] No [ ]
   If yes, date of repairs/replacement: ____/____/____
8. Plumbing System(s): Any known problems? Yes [ ] No [ ]
   Any known repairs? Yes [ ] No [ ]
   If yes, date of repairs/replacement: ____/____/____
9. Electrical System(s): Any known problems? Yes [ ] No [ ]
   Any known repairs? Yes [ ] No [ ]
   If yes, date of repairs/replacement: ____/____/____
10. Pest Infestation (e.g., termites, carpenter ants): Any known problems? Yes [ ] No [ ]
    If yes, date(s) of treatment: ____/____/____
    Any known structural damage? Yes [ ] No [ ]
    If yes, date(s) of repairs/replacement: ____/____/____
11. Asbestos: Any known to be present in the structure? Yes [ ] No [ ]
    If yes, explain: _____
12. Radon: Any known tests for the presence of radon gas? Yes [ ] No [ ]
    If yes, date of last report: ____/____/____
    and results: _____
13. Lead-Based Paint: Any known to be present in the structure? Yes [ ] No [ ]
14. Flood Plain: Do you know if the property is located in a flood plain? Yes [ ] No [ ]
    If yes, what is the flood plain designation? _____
15. Zoning: Do you know the zoning classification of the property? Yes [ ] No [ ]
    If yes, what is the zoning classification? _____
16. Covenants: Is the property subject to restrictive convenants? Yes [ ] No [ ]
    If yes, attach a copy or state where a true, current copy of the convenants can be obtained:
    _____
17. Shared or Co-Owned Features: Any features of the property known to be shared in common with adjoining landowners, such as walls, fences, roads, and driveways whose use or maintenance responsibility may have an effect on the property? Yes [ ] No [ ]
    Any known *"common areas"* such as pools, tennis courts, walkways, or other areas co-owned with others, or a Homeowner's Association which has any authority over the property? Yes [ ] No [ ]
18. Physical Problems: Any known settling, flooding, drainage or grading problems? Yes [ ] No [ ]
19. Structural Damage: Any known structural damage? Yes [ ] No [ ]

You **MUST** explain any *"YES"* response(s) above. Use the back of this statement or additional sheets as necessary: _____
_____
_____
_____

SELLER(S) DISCLOSURE:

Seller(s) discloses the information regarding this property based on information known or reasonably available to the Seller(s).
The Seller(s) has owned the property since ____/____/____. The Seller(s) certifies that as of the date signed this information is true and accurate to the best of my/our knowledge.

Seller_____ Seller_____
Date ____/____/____ Date ____/____/____

BUYER(S) ACKNOWLEDGMENT:
Buyer(s) acknowledges receipt of a copy of this Real Estate Disclosure Statement. This statement is not intended to be a warranty or to substitute for any inspection the buyer(s) may wish to obtain.

Buyer_____ Buyer_____
Date ____/____/____ Date ____/____/____

This rule is intended to implement Iowa Code chapters 17A, 272C, 543B, and 558A.
[**ARC 7950B**, IAB 7/15/09, effective 8/19/09]

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[Editorial change: IAC Supplement 9/10/08]
[Filed ARC 7950B (Notice ARC 7639B, IAB 3/25/09), IAB 7/15/09, effective 8/19/09]

CHAPTER 10
INTRASTATE GAS AND UNDERGROUND GAS STORAGE
[Prior to 10/8/86, Commerce Commission[250]]

199—10.1(479) General information.

10.1(1) *Authority.* The standards relating to intrastate gas and underground gas storage in this chapter are prescribed by the Iowa utilities board (board) pursuant to Iowa Code section 479.17.

10.1(2) *Purpose.* The purpose of this chapter is to establish standards for a petition for a permit to construct, maintain, and operate an intrastate gas pipeline and for the underground storage of gas. In addition, the rules in this chapter set forth safety standards for the construction, maintenance, and condition of pipelines, underground storage facilities, and equipment used in connection with pipelines and facilities.

10.1(3) *Definitions.* Technical terms not defined in this chapter shall be as defined in the appropriate standard adopted in rule 199—10.12(479). For the administration and interpretation of this chapter, the following words and terms, when used in these rules, shall have the meanings indicated below:

"Approximate right angle" means within 5 degrees of a 90 degree angle.

"Board" means the utilities board within the utilities division of the department of commerce.

"Multiple line crossing" means a point at which a proposed pipeline will either overcross or undercross an existing pipeline.

"Permit" means a new, amended, or renewal permit issued after appropriate application to and determination by the board.

"Pipeline" means any pipe, pipes, or pipelines used for the intrastate transportation or transmission of any solid, liquid, or gaseous substance, except water.

"Pipeline company" means any person, firm, copartnership, association, corporation, or syndicate engaged in or organized for the purpose of owning, operating, or controlling pipelines for the intrastate transportation or transmission of any solid, liquid, or gaseous substance, except water.

"Renewal permit" means the extension and reissuance of a permit after appropriate application to and determination by the board.

"Underground storage" means storage of gas in a subsurface stratum or formation of the earth.

10.1(4) *Railroad crossings.* Where these rules call for the consent or other showing of right from a railroad for a railroad crossing, an affidavit filed by a petitioner which states that proper application for approval of railroad crossing has been made, that a one-time crossing fee has been paid as provided for in rule 199—42.3(476), and that 35 days have passed since mailing of the application and payment with no claim of special circumstance or objection from the railroad will be accepted as a showing of consent for the crossing.

199—10.2(479) Petition for permit.

10.2(1) A petition for a permit shall be made to the board upon the form prescribed and shall include all required exhibits. The petition shall be considered as filed upon receipt at the office of the board. An original and two copies of the petition and exhibits shall be filed, unless the petition and exhibits are filed electronically pursuant to the board's electronic filing rules at 199—Chapter 14. Required exhibits shall be in the following form:

a. Exhibit A. A legal description showing, at minimum, the general direction of the proposed route through each quarter section of land to be crossed, including township and range and whether on private or public property, public highway or railroad right-of-way, together with such other information as may be deemed pertinent. Construction deviation of 660 feet (one-eighth mile) from proposed routing will be permitted.

If it becomes apparent that there will be deviation of greater than 660 feet (one-eighth mile) in some area from the proposed route as filed with the board, construction of the line in that area shall be suspended. Exhibits A, B, E, and F reflecting the deviation shall be filed, and the procedures hereinafter set forth to be followed upon the filing of a petition for permit shall be followed.

b. Exhibit B. Maps showing the proposed routing of the pipeline. Strip maps will be acceptable. Two copies of such maps shall be filed. The maps may be to any scale appropriate for the level of detail to be shown, but not smaller than one inch to the mile. The following minimum information shall be provided:

(1) The route of the pipeline which is the subject of the petition, including the starting and ending points, and when paralleling a road or railroad, which side it is on. Multiple pipelines on the same right-of-way shall be indicated.

(2) The name of the county, county and section lines, and section, township and range numbers.

(3) The location and identity of public roads, railroads, major streams or bodies of water, and other pertinent natural or man-made features influencing the route.

(4) The name and corporate limits of cities, and the name and boundaries of any public lands or parks.

(5) Other pipelines and the identity of the owner.

c. Exhibit C. A showing on forms prescribed by this board of engineering specifications covering the engineering features, materials and manner of construction of the proposed pipeline, its approximate length, diameter and the name and location of each railroad and primary highway and the number of secondary highways to be crossed, if any, and such other information as may be deemed pertinent.

d. Exhibit D. Satisfactory attested proof of solvency and financial ability to pay damages in the sum of $250,000 or more; or surety bond satisfactory to this board in the penal sum of $250,000 with surety approved by this board, conditioned that the petitioner will pay any and all damages legally recovered against it growing out of the operation of its pipeline or gas storage facilities in the state of Iowa; security satisfactory to this board as a guarantee for the payment of damages in the sum of $250,000; or satisfactory proofs that the company has property subject to execution within this state, other than pipelines, of a value in excess of $250,000.

e. Exhibit E. Consent or other showing of right of appropriate public highway authorities, or railroad companies, where the pipeline will be placed longitudinally on, over or under, or at other than an approximate right angle to railroad tracks or highway, when such consent is obtained prior to filing of the petition and hearing shall be filed with the petition.

If the exact and specific route is uncertain at the time of petition, a statement shall be made by petitioner that all consents or other showing of right will be obtained prior to construction and copies filed with this board.

f. Exhibit F. This exhibit shall contain the following:

(1) A statement of the purpose of the project and a description of how the services rendered by the pipeline will promote the public convenience and necessity.

(2) A general statement covering each of the following topics: the nature of the lands, waters, and public or private facilities to be crossed; the possible use of alternative routes; the relationship of the proposed pipeline to present and future land use and zoning ordinances; and the inconvenience or undue injury which may result to property owners as a result of the proposed project.

(3) For an existing pipeline, the year of original construction and a description of any amendments or reportable changes since the permit or latest renewal permit was issued.

g. Exhibit G. If informational meetings were required, an affidavit that such meetings were held in each county affected by the proposed project and the time and place of each meeting. Copies of the mailed notice letter and the published notice(s) of the informational meeting shall be attached to the affidavit.

h. Exhibit H. This exhibit is required only if the petition requests the right of eminent domain. The extent of the eminent domain request may be uncertain at the time the petition is filed. However, this exhibit must be in final form before a hearing is scheduled. It shall consist of a map of the route showing the location of each property for which the right of eminent domain is sought and for each such property:

(1) The legal description of the property.

(2) The legal description of the desired easement.

(3) A specific description of the easement rights being sought.

(4) The names and addresses of the owners of record and parties in possession of the property.

(5) A map drawn to an appropriate scale showing the boundaries of the property, the boundaries and dimensions of the proposed easement, the location of pipelines or pipeline facilities within the proposed easement, the location of and distance to any building within 300 feet of the proposed pipeline, and any other features pertinent to the location of the line to the rights being sought.

i. Exhibit I. If pipeline construction on agricultural land as defined in 199—subrule 9.1(3) is proposed, a land restoration plan shall be prepared and filed as provided in rule 199—9.2(479,479A,479B).

j. Underground storage. If permission is sought to construct, maintain and operate facilities for underground storage of gas, the petition shall include the following information, in addition to that stated above:

(1) A description of the public or private highways, grounds and waters, streams and private lands of any kind under which the storage is proposed, together with a map.

(2) Maps showing the location of proposed machinery, appliances, fixtures, wells, and stations necessary for the construction, maintenance, and operation of the facilities.

k. Other exhibits. The board may require filing of additional exhibits if further information on a particular project is deemed necessary.

10.2(2) Petitions proposing new pipeline construction on an existing easement where the company has previously constructed a pipeline shall include a statement indicating whether any unresolved damage claims remain from the previous pipeline construction, and if so shall provide the name of each landowner or tenant, a legal description of the property involved, and the status of proceedings to settle the claim.

A petition for permit proposing a new pipeline construction on an existing easement where the company has previously constructed a pipeline will not be acted upon by the board if a damage claim from the installation of its previous pipeline has not been determined by negotiation, arbitration, or court action. This paragraph will not apply if the damage claim is under litigation or arbitration.

10.2(3) Statement of damage claims.

a. A petition for permit proposing new pipeline construction will not be acted upon by the board if the company does not have on file with the board a written statement as to how damages resulting from the construction of the pipeline shall be determined and paid.

The statement shall contain the following information: the type of damages which will be compensated for, how the amount of damages will be determined, the procedures by which disputes may be resolved, and the manner of payment.

The statement shall be amended as necessary to reflect changes in the law, company policy, or the needs of a specific project.

b. A copy of this statement shall be mailed with the notice of informational meeting as provided for in Iowa Code section 479.5. Where no informational meeting is required, a copy shall be provided to each affected party prior to entering into negotiations for payment of damages.

c. Nothing in this rule shall prevent a party from negotiating with the company for terms which are different, more specific, or in addition to the statement filed with the board.

This rule is intended to implement Iowa Code sections 479.5, 479.17, 479.26, 479.42, and 479.43.

199—10.3(479) Informational meetings. Informational meetings shall be held for any proposed pipeline project over five miles in length, including both the current project and future anticipated extensions, and which is to be operated at a pressure of over 150 pounds per square inch. A separate informational meeting shall be held in each county in which real property or rights therein would be affected. Informational meetings shall be held not less than 30 days nor more than two years prior to the filing of the petition for pipeline permit and shall comply with the following:

10.3(1) *Facilities.* Prospective petitioners for a permit shall be responsible for all negotiations and compensation for a suitable facility to be used for each informational meeting, including but not limited to a building or facility which is in substantial compliance with the requirements of the Americans with Disabilities Act Accessibility Guidelines, Chapter 4, where such a building or facility is reasonably available.

10.3(2) *Location.* The informational meeting location shall be reasonably accessible to all persons, companies or corporations which may be affected by the granting of a permit.

10.3(3) *Route deviation.* Prospective petitioners desiring a route corridor to permit minor route deviations beyond the proposed permanent right of way width shall include as affected all parties within the desired corridor. Prospective petitioners may also provide notice to affected parties on alternative route corridors.

10.3(4) *Notices.* Announcement by mailed and published notice of the meeting shall be given to affected parties of interest in real estate. Affected parties of interest in real estate are those persons, companies or corporations listed on the tax assessment roles as responsible for payment of real estate taxes and parties in possession of or residing on the property over which the prospective petitioner will seek easements.

a. The notice shall set forth the name of the applicant; the applicant's principal place of business; the general description and purpose of the proposed project; the general nature of the right-of-way desired; the possibility that the right-of-way may be acquired by condemnation if approved by the board; a map showing the route of the proposed project; a description of the process used by the board in making a decision on whether to approve a permit including the right to take property by eminent domain; that the landowner has a right to be present at such meeting and to file objections with the board; and designation of the time and place of the meeting; and contain the following statement: Persons with disabilities requiring assistive services or devices to observe or participate should contact the Utilities Board at (515)281-5256 in advance of the scheduled date to request that appropriate arrangements be made. Mailed notices shall also include a copy of the statement of damage claims as required by 10.2(3)*"b."*

b. The prospective petitioner shall cause a written copy of the meeting notice to be served, by certified United States mail with return receipt requested, on all affected parties whose address is known. The certified meeting notice shall be deposited in the U.S. mails not less than 30 days prior to the date of the meeting.

c. The prospective petitioner shall cause the meeting notice, including the map, to be published once in a newspaper of general circulation in the county at least one week and not more than three weeks prior to the date of the meeting. Publication shall be considered as notice to affected parties whose residence is not known provided a good-faith effort to notify can be demonstrated by the pipeline company.

10.3(5) *Personnel.* The prospective petitioner shall provide qualified personnel to speak for it in matters relating to the following:

a. Service requirements and planning which have resulted in the proposed project.

b. When the pipeline will be constructed.

c. In general terms, the elements involved in pipeline construction.

d. In general terms, the rights which the prospective petitioner will seek to acquire through easements.

e. Procedures to be followed in contacting affected parties for specific negotiations in acquiring voluntary easements.

f. Methods and factors used in arriving at an offered price for voluntary easements including the range of cash amount for each component.

g. Manner in which voluntary easement payments are made, including discussion of conditional easements, signing fees and time of payment.

h. Other factors or damages not included in the easement for which compensation is made, including features of interest to affected parties but not limited to computation of amounts and manner of payment.

10.3(6) *Coordinating with board.* The date, time, and location of the informational meeting shall be selected after consultation with the board to allow for scheduling of presiding officers.

This rule is intended to implement Iowa Code section 479.5.

199—10.4(479) Notice of hearing.

10.4(1) When a proper petition for permit is received by the board, it shall be docketed for hearing and the petitioner shall be advised of the time and place of hearing, except as provided for in rule 199—10.8(479). Petitioner shall also be furnished copies of the official notice of hearing which petitioner shall cause to be published once each week for two consecutive weeks in a newspaper of general circulation in each county in or through which construction is proposed. The second publication shall be not less than 10 nor more than 30 days prior to the date of the hearing. Proof of such publication shall be filed prior to or at the hearing.

The published notice shall include a map showing either the pipeline route or the area affected by underground gas storage, or a telephone number and an address through which interested persons can obtain a copy of a map from petitioner at no charge. If a map other than that filed as Exhibit B will be published or provided, a copy shall be filed with the petition.

10.4(2) If a petition for permit seeks the right of eminent domain, petitioner shall, in addition to the published notice of hearing, serve a copy of the notice of hearing to the owners and parties in possession of lands over which eminent domain is sought. A copy of the Exhibit H filed with the board for the affected property shall accompany the notice. Service shall be by certified United States mail, return receipt requested, addressed to their last known address, and this notice shall be mailed not later than the first day of publication of the official notice of hearing on the petition. Not less than five days prior to the date of the hearing, the petitioner shall file with the board a certificate of service showing all addresses to which notice was sent by certified mail and the date of the mailing.

10.4(3) If a petition does not seek the right of eminent domain, but all required interests in private property have not yet been obtained, a copy of the notice of hearing shall be served upon the owners and parties in possession of those lands. Service shall be by ordinary mail, addressed to the last known address, mailed not later than the first day of publication of the official notice. A copy of each letter of notification, or one copy of the letter accompanied by a written statement listing all parties to which it was mailed and the date of mailing, shall be filed with the board not less than five days prior to the hearing.

199—10.5(479) Objections. All whose rights or interests may be affected by the object of a petition may file written objection thereto. Such written objection shall be filed with the secretary of this board not less than five days prior to date of hearing. This board may, for good cause shown, permit filing of objections less than five days prior to hearing, but in such event petitioner shall be granted a reasonable time to meet such objections.

199—10.6(479) Hearing. Hearing shall be not less than 10 or more than 30 days from the date of last publication of notice of hearing.

Petitioner shall be represented by one or more duly authorized representatives or counsel or both. This board may examine the proposed route of the pipeline or location of the underground storage facilities which are the object of the petition or may cause examination to be made on its behalf by an engineer of its selection. One or more members of this board or a duly appointed administrative law judge shall consider the petition and any objections filed thereto and may hear testimony deemed appropriate. One or more petitions may be considered at the same hearing. Petitions may be consolidated. Hearing shall be held in the office of this board or at any other place within the state of Iowa as this board may designate. Any hearing permitted by these rules in which there are no objections, interventions or material issues in dispute may be conducted by telephonic means. Notice of the telephonic hearings shall be given to parties within a reasonable time prior to the date of hearing.

199—10.7(479) Pipeline permit. If after hearing and appropriate findings of fact it is determined a permit should be granted, a pipeline permit shall be issued. Otherwise the petition shall be dismissed with or without prejudice. Where proposed construction has not been established definitely, the permit will be issued on the route or location as set forth in the petition, subject to deviation of up to 660 feet (one-eighth mile) on either side of the proposed route. If the proposed construction is not completed

within two years from the date of issue, subject to extension at the discretion of the board, the permit shall be void and of no further force or effect. Upon completion of the proposed construction, maps accurately showing the final routing of the pipeline shall be filed with the board.

A pipeline permit shall normally expire 25 years from date of issue. No permit shall ever be granted for a longer period than 25 years.

199—10.8(479) Renewal permits. A petition for renewal of an original or previously renewed pipeline permit may be filed at any time subsequent to issuance of the permit and prior to expiration of the permit. The petition shall be made on the form prescribed by the board. Instructions for the petition are included as a part of the form. The procedure for petition for permit shall be followed with respect to publication of notice, objections, and assessment of costs. If review of the petition finds unresolved issues of fact or law, or if an objection is filed within 20 days of the second publication of the published notice, the matter will be set for hearing. If a hearing is not required, a renewal permit will be issued upon the filing of the proof of publication required by 199—10.4(479). Renewal permits shall normally expire 25 years from date of issue. No permit shall be granted for a period longer than 25 years. The same procedure shall be followed for subsequent renewals.

This rule is intended to implement Iowa Code sections 476.2 and 479.23.

199—10.9(479) Amendment of permits.

10.9(1) An amendment of pipeline permit by the board is required in any of the following circumstances:

a. Construction of a pipeline paralleling an existing line of petitioner;

b. Extension of an existing pipeline of petitioner by more than 660 feet (one-eighth mile);

c. Relocation of an existing pipeline of petitioner which:

(1) Relocates the pipeline more than 660 feet (one-eighth mile) from the route approved by the board; or

(2) Involves relocation requiring new or additional interests in property for five miles or more of pipe to be operated at over 150 psig. Informational meetings as provided for by rule 199—10.3(479) shall be held for these relocations.

d. Contiguous extension of an underground storage area of petitioner; or

e. Modification of any condition or limitation placed on the construction or operation of the pipeline in the final order granting the pipeline permit.

10.9(2) Petition for amendment. The petition for amendment of an original or renewed pipeline permit shall include the docket number and issue date of the permit for which amendment is sought and shall clearly state the purpose of the petition. If the petition is for construction of additional pipeline facilities or expansion of an underground storage area, the same exhibits as required for a petition for permit shall be attached.

The applicable procedures for petition for permit, including hearing, shall be followed. Upon appropriate determination by this board, an amendment to the permit will be issued. Such amendment shall be subject to the same conditions with respect to completion of construction within two years and the filing of final routing maps as attached to pipeline permits.

This rule is intended to implement Iowa Code sections 476.2 and 479.23.

199—10.10(479) Fees and expenses.

10.10(1) *Permit expenses.* The petitioner shall pay the actual unrecovered cost incurred by the board attributable to the processing, investigation, and inspection related to a petition requesting a pipeline permit action.

Any moneys collected by the board from other sources for chargeable activities will be deducted from billings for actual expenses submitted to the petitioner.

10.10(2) *Construction inspection.* The petitioner shall reimburse the board for the actual unrecovered expenses incurred due to inspection of pipeline construction or testing activities following from a permit action.

Any moneys collected by the board from other sources for chargeable activities will be deducted from billings for actual expenses submitted to the petitioner.

10.10(3) *Annual inspection fee.* A pipeline company shall pay an annual inspection fee on all pipelines under permit of 50 cents per mile of pipeline or fraction thereof for each inch of diameter of the pipeline located in the state of Iowa. The fee shall be paid for the calendar year in advance between January 1 and February 1 of each year. When new pipeline subject to the fee is installed, the fee shall be paid beginning the following calendar year. Pipelines removed from service shall remain subject to the fee until the calendar year following the year the board is notified of the removal from service in accordance with rule 10.18(479).

199—10.11(479) Inspections. This board shall from time to time examine the construction, maintenance and condition of pipelines, underground storage facilities and equipment used in connection with pipelines or facilities in the state of Iowa to determine if the same are unsafe or dangerous and whether they comply with the appropriate standards of pipeline safety. One or more members of this board, or one or more duly appointed representatives of the board may enter upon the premises of any pipeline company within the state of Iowa for the purpose of making the inspections.

199—10.12(479) Standards for construction, operation and maintenance.

10.12(1) All pipelines, underground storage facilities, and equipment used in connection therewith shall be designed, constructed, operated, and maintained in accordance with the following standards:

a. 49 CFR Part 191, "Transportation of Natural and Other Gas by Pipeline; Annual Reports, Incident Reports, and Safety-Related Condition Reports," as amended through August 19, 2009.

b. 49 CFR Part 192, "Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards," as amended through August 19, 2009.

c. 49 CFR Part 199, "Drug and Alcohol Testing," as amended through August 19, 2009.

d. ASME B31.8 - 2007, "Gas Transmission and Distribution Piping Systems."

e. 199 IAC 9, "Restoration of Agricultural Lands During and After Pipeline Construction."

f. At railroad crossings, 199 IAC 42.7(476), "Engineering standards for pipelines."

Conflicts between the standards established in paragraphs 10.12(1)*"a"* through *"f"* or between the requirements of rule 199—10.12(479) and other requirements which are shown to exist by appropriate written documentation filed with the board shall be resolved by the board.

10.12(2) If review of Exhibit C, or inspection of facilities which are the subject of a permit petition, finds noncompliance with the standards adopted in this rule, no final action will be taken by the board on the petition without a satisfactory showing by the petitioner that the noncompliance has been or will be corrected.

10.12(3) Pipelines in tilled agricultural land shall be installed with a minimum cover of 48 inches.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—10.13(479) Minimum safety standards. Rescinded IAB 2/21/90, effective 3/28/90.

199—10.14(479) Crossings of highways, railroads, and rivers.

10.14(1) Iowa Code chapter 479 gives the Iowa utilities board primary authority over the routing of pipelines. However, highway and railroad authorities and environmental agencies may have a jurisdictional interest in the routing of the pipeline, including requirements that permits or other authorizations be obtained prior to construction for crossings of highway or railroad right-of-way, or rivers or other bodies of water.

Except for other than approximate right angle crossings of highway or railroad right-of-way, the approval of other authorities need not be obtained prior to petitioning the board for a pipeline permit. It is recommended the appropriate other authorities be contacted well in advance of construction to determine what restrictions or conditions may be placed on the crossing, and to obtain information on any proposed reconstruction or relocation of existing facilities which may impact the routing of the pipeline.

10.14(2) Pipeline routes which include crossings of highway or railroad right-of-way at other than an approximate right angle, or longitudinally on such right-of-way, shall not be constructed unless a showing

of consent by the appropriate authority has been provided by the petitioner as required in paragraph 10.2(1)*"e."*

199—10.15(479) River crossings. Rescinded IAB 3/6/91, effective 4/10/91.

199—10.16(479) When a permit is required. A pipeline permit shall be required for any pipeline which will be operated at a pressure of over 150 pounds per square inch gage or which, regardless of operating pressure, is a transmission line as defined in ASME B31.8 or 49 CFR Part 192. Questions on whether a pipeline requires a permit are to be resolved by the board.

199—10.17(479) Accidents and incidents. Any pipeline incident or accident which is reportable to the U.S. Department of Transportation under 49 CFR Part 191 as amended through August 19, 2009, shall also be reported to the board, except that the minimum economic threshold of damage required for reporting to the board is $15,000. Duplicate copies of any written accident reports and safety-related condition reports submitted to the U.S. Department of Transportation shall be provided to the board.
[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—10.18(479) Reportable changes to pipelines under permit.

10.18(1) The board shall receive prior notice of any of the following actions affecting a pipeline under permit:

a. Abandonment or removal from service.

b. Relocation of more than 300 feet from the original alignment, or any relocation that would bring the pipeline within 300 feet of an occupied residence. Relocations of 660 feet (one-eighth mile) or more shall require the filing of a petition for permit.

c. Pressure test, uprating, or increase in operating pressure.

d. Change in product being transported.

e. Replacement of a pipeline or significant portion thereof, not including short repair sections of pipe at least as strong as the original pipe.

f. Extensions of existing pipelines by 660 feet (one-eighth mile) or less.

10.18(2) The notice shall include the docket and permit numbers of the pipeline, the location involved, a description of the proposed activity, anticipated dates of commencement and completion, revised maps and technical specifications, where appropriate, and the name and telephone number of a person to contact for additional information.

199—10.19(479) Sale or transfer of permit.

10.19(1) No permit shall be sold without prior written approval of the board. A petition for approval shall be jointly filed by the buyer and seller, shall include assurances that the buyer is authorized to transact business in the state of Iowa; is willing and able to construct, operate, and maintain the pipeline in accordance with these rules; and if the sale is prior to completion of construction of the pipeline shall show that the buyer has the financial ability to pay up to $250,000 in damages.

10.19(2) No transfer of pipeline permit prior to completion of pipeline construction shall be effective until the person to whom the permit was issued files notice with the board of the transfer. The notice shall include the date of the transfer and the name and address of the transferee.

10.19(3) The board shall receive notice from the transferor of any other transfer of a pipeline permit after completion of construction.

For the purposes of this rule, reassignment of a pipeline permit as part of a corporate restructuring, with no change in pipeline operating personnel or procedures, is considered a transfer.

199—10.20(479) Amendments to rules. Rescinded IAB 6/25/03, effective 7/30/03.

These rules are intended to implement Iowa Code sections 476.2, 479.5, 479.17, 479.23, 479.26, 479.42, 479.43 and 546.7.

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CHAPTER 19
SERVICE SUPPLIED BY GAS UTILITIES
[Prior to 10/8/86, Commerce Commission [250]]

199—19.1(476) General information.

19.1(1) *Authorization of rules.* Iowa Code chapter 476 provides that the Iowa utilities board shall establish all needful, just and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties, the practice and procedure before it, and to govern the form, contents and filing of reports, documents and other papers necessary to carry out the provisions of this law.

Iowa Code chapter 479 provides that the Iowa utilities board shall have full authority and power to promulgate rules as it deems proper and expedient in the supervision of the transportation or transmission and underground storage of gas within the state of Iowa.

The application of the rules in this chapter to municipally owned utilities furnishing gas is limited by Iowa Code section 476.1B.

19.1(2) *Application of rules.* The rules shall apply to any gas utility operating within the state of Iowa as defined in Iowa Code chapter 476 and shall supersede any tariff on file with this board which is in conflict with these rules. These rules are intended to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities. A request to waive the application of any rule on a permanent or temporary basis may be made in accordance with rule 199—1.3(17A,474,476,78GA,HF2206). The adoption of these rules shall in no way preclude the board from altering or amending them, pursuant to statute, or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions. These regulations shall in no way relieve any utility from any of its duties under the laws of this state.

19.1(3) *Definitions.* The following words and terms, when used in these rules shall have the meaning indicated below:

The abbreviations used, and their meanings, are as follows:

Btu—British thermal unit

LP-Gas—Liquefied Petroleum Gas

psig—Pounds per Square Inch, Gauge

W.C.—Water Column

"Appliance" refers to any device which utilizes gas fuel to produce light, heat or power.

"Board" means the Iowa utilities board.

"Complaint" as used in these rules is a statement or question by anyone, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or utility failure to fulfill an obligation.

"Cubic foot" of gas has the following meanings:

1. Where gas is supplied and metered to customers at the pressure (as defined in 19.7(2)) normally used for domestic customers' appliances, a cubic foot of gas shall be that quantity of gas which, at the temperature and pressure existing in the meter, occupies one cubic foot, except that where a temperature compensated meter is used, the temperature base shall be 60°F.

2. When gas is supplied to customers at other than the pressure in (1) above, the utility shall specify in its rules the base for measurement of a cubic foot of gas (see 19.2(4)*"c"*(6)). Unless otherwise stated by the utility, such cubic foot of gas shall be that quantity of gas which, at a temperature of 60°F and a pressure of 14.73 pounds per square inch absolute, occupies one cubic foot.

3. The standard cubic foot of gas for testing the gas itself for heating value shall be that quantity of gas, saturated with water vapor, which, at a temperature of 60°F and a pressure of 30 inches of mercury, occupies one cubic foot. (Temperature of mercury = 32°F acceleration due to gravity = 32.17 ft. per second per second density = 13.595 grams per cubic centimeter.)

"Customer" means any person, firm, association, or corporation, any agency of the federal, state or local government, or legal entity responsible by law for payment for the gas service or heat from the gas utility.

"Delinquent" or *"delinquency"* means an account for which a service bill or service payment agreement has not been paid in full on or before the last day for timely payment.

"Gas," unless otherwise specifically designated, means manufactured gas, natural gas, other hydrocarbon gases, or any mixture of gases produced, transmitted, distributed or furnished by any gas utility.

"Gas plant" means all facilities including all real estate, fixtures and property owned, controlled, operated or managed by a gas utility for the production, storage, transmission and distribution of gas and heat.

"Heating and calorific values." The following values shall be used:

1. *"British thermal unit"* (Btu) is the quantity of heat that must be added to one avoirdupois pound of pure water to raise its temperature from 58.5°F to 59.5°F under standard pressure.

2. *"Dry calorific value"* of a gas (total or net) is the value of the total or the net calorific value of the gas divided by the volume of dry gas in a standard cubic foot.

NOTE: The amount of dry gas in a standard cubic foot is .9826 cubic foot.

3. *"Net calorific value"* of a gas is the number of British thermal units evolved by the complete combustion, at constant pressure, of one standard cubic foot of gas with air, the temperature of the gas, air, and products of combustion being 60°F and all water formed by the combustion reaction remaining in the vapor state.

NOTE: The net calorific value of a gas is its total calorific value minus the latent heat of evaporation at standard temperature of the water formed by the combustion reaction.

4. *"Therm"* means 100,000 British thermal units.

5. *"Total calorific value"* of a gas is the number of British thermal units evolved by the complete combustion, at constant pressure, of one standard cubic foot of gas with air, the temperature of the gas, air and products of combustion being 60°F and all water formed by the combustion reaction condensed to the liquid state.

"Interruption of service" means any disturbance of the gas supply whereby gas service to a customer cannot be maintained.

"Loss factor" as used in rule 19.10(476) means test-year purchases less test-year sales. A five-year average of purchases less sales may be used if the test year is determined by the board to be abnormal.

"Main" means a gas pipe, owned, operated, or maintained by a utility, which is used for the purpose of transmission or distribution of gas, but does not include "service line".

"Meter," without other qualification, shall mean any device or instrument which is used by a utility in measuring a quantity of gas.

"Meter shop" is a shop where meters are inspected, repaired and tested, and may be at a fixed location or may be mobile.

"Pressure," unless otherwise stated, is expressed in pounds per square inch above atmospheric pressure, i.e., gauge pressure (abbreviation-psig).

"Rate-regulated utility" means any utility as defined in the definition of "utility" below which is subject to rate regulation provided for in Iowa Code chapter 476.

"Service line" means a distribution line that transports gas from a common source of supply to a customer meter or the connection to a customer's piping, whichever is farther downstream, or the connection to a customer's piping if there is not a customer meter. A customer meter is the meter that measures the transfer of gas from a utility to a customer.

"Tap" or *"town border station"* means the delivery point or measuring station at which a gas distribution utility receives gas from a natural gas transmission company.

"Tariff" means the entire body of rates, tolls, rentals, charges, classifications, rules, procedures, policies, etc., adopted and filed with the board by a gas utility in fulfilling its role of furnishing gas service.

"Timely payment" is a payment on a customer's account made on or before the date shown on a current bill for service or on a form which records an agreement between the customer and a utility for a series of partial payments to settle a delinquent account, as the date which determines application of a late payment charge to the current bill or future collection efforts.

"Utility" means any person, partnership, business association, or corporation, domestic or foreign, owning or operating any facilities for furnishing gas or heat to the public for compensation.

199—19.2(476) Records, reports, and tariffs.

19.2(1) *Location and retention of records.* Unless otherwise specified in this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of Chapter 18 of the board's rules, Utility Records.

19.2(2) *Tariffs to be filed with the board.* The schedules of rates and rules of rate-regulated gas utilities shall be filed with the board and shall be classified, designated, arranged and submitted so as to conform to the requirements of this chapter. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification and content of tariffs shall be in accordance with these rules.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not be required to file schedules of rates, rules, or contracts primarily concerned with a rate schedule with the board, but nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules or contracts which are needed by the board in the performance of the board's duties upon request to do so by the board.

19.2(3) *Form and identification.* All tariffs shall conform to the following rules:

a. The tariff shall be printed, typewritten or otherwise reproduced on 8½- × 11- inch sheets of durable white paper so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding. In the case of utilities subject to regulation by any federal agency the format of sheets of tariff as filed with the board may be the same format as is required by the federal agency provided that the rules of the board as to title page; identity of superseding, replacing or revision sheets; identity of amending sheets; identity of the filing utility, issuing official, date of issue, effective date; and the words, "Gas Tariff Filed with Board" shall apply in the modification of the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show:

(1) The first page shall be the title page which shall show:

(Name of Public Utility)
Gas Tariff
Filed with
Iowa Utilities Board

(date)

(This requirement does not apply to tariffs or amendments filed with the board prior to April 1, 1982.)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on the upper right corner of its title page that it is a revision of a tariff on file and the number being superseded or replaced, for example:

Tariff No. _____
Supersedes Tariff No. _____

(This requirement does not apply to tariffs or amendments filed with the board prior to April 1, 1982.)

(3) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly identify the part eliminated.

(4) Any tariff modifications as defined in "3" above replacing tariff sheets shall be marked in the right margin with symbols as herein described to indicate the place, nature and extent of the change in text.

Symbol	*Meaning*
(C)	A change in regulation
(D)	A discontinued rate, treatment or regulation
(I)	An increased rate or new treatment resulting in increased rate

Symbol	*Meaning*
(N)	A new rate, treatment or regulation
(R)	A reduced rate or new treatment resulting in a reduced rate
(T)	A change in text but no change in rate, treatment or regulation

c. All sheets except the title page shall have, in addition to the above-stated requirements, the following information:

(1) Name of utility under which shall be set forth the words "Filed with Board." If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.

(2) Issuing official and issue date.

(3) Effective date (to be left blank by rate-regulated utilities).

d. All sheets except the title page shall have the following form:

(Company Name)	(Part identification)
Gas Tariff	(This sheet identification)
Filed with board	(Canceled sheet identification, if any)
(Content of tariff)	
Issued: (Date)	Effective:
Issued by: (Name, title)	(Proposed Effective Date:)

The issued date is the date the tariff or the amended sheet content was adopted by the utility.

The effective date will be left blank by rate-regulated utilities and shall be determined by the board. The utility may propose an effective date.

19.2(4) *Content of tariffs.* A tariff filed with the board shall contain:

a. A table of contents containing a list of rate schedules and other sections in the order in which they appear showing the sheet number of the first page of each section.

b. All rates of utilities subject to rate regulation for service with indication of each rate for the type of gas and the class of customers to which each rate applies. There shall also be shown the prices per unit of service, the number of units per billing period to which the prices apply, the period of billing, the minimum bill, the method of measuring demands and consumptions, including the method of calculating or estimating loads or minimums, delivery pressure, and any special terms or conditions applicable. All rates should be separated into "gas" and "nongas" components, and books and records shall be maintained on this basis. Books and records shall be available to the board for audits upon request. The gas components will be the result of the utility's periodic review of gas procurement practices rule (19.11(476)) and PGA (rule 19.10(476)) proceeding. The nongas components will be established through rate case proceedings under Iowa Code section 476.3 or 476.6. The period during which the net amount may be paid before the account becomes delinquent shall be specified. In any case where net and gross amounts are billed, the difference between net and gross is a late payment charge and shall be so specified.

Customer charges for all special services relating to providing the basic utility service including, but not limited to, reconnect charge and different categories of service calls shall be specified.

c. A copy of the utility's rules, or terms and conditions, describing the utility's policies and practices in rendering service shall include:

(1) A statement as to the equivalent total heating value of the gas in Btu's per cubic foot on which their customers are billed. If necessary, this may be listed by district, division or community.

(2) The list of the items which the utility furnishes, owns, and maintains on the customer's premises, such as service pipe, meters, regulators, vents and shut-off valves.

(3) General statement indicating the extent to which the utility will provide service in the adjustment of customer appliances at no additional customer charge.

(4) General statement of the utility's policy in making adjustments for wastage of gas when such wastage occurs without the knowledge of the customer.

(5) A statement indicating the minimum number of days allowed for payment after the due date of the customer's bill before service will be discontinued for nonpayment.

(6) A statement indicating the volumetric measurement base to which all sales of gas at other than standard delivery pressure are corrected.

(7) Forms of standard contracts required of customers for the various types of service available.

(8) All tariffs must provide that, notwithstanding any other provision of this tariff or contract with reference thereto, all rates and charges contained in this tariff or contract with reference thereto may be modified at any time by a subsequent filing made pursuant to the provisions of Iowa Code chapter 476.

(9) A copy of each type of customer bill.

(10) Definitions of classes of customer.

(11) Rules for extending service in accordance with 19.3(10).

(12) Rules with which prospective customers must comply as a condition of receiving service, and the terms of contracts required.

(13) Rules governing the establishment and maintenance of credit by customers for payment of service bills.

(14) Rules governing disconnecting and reconnecting service.

(15) Notice required from customer for having service discontinued.

(16) Rules covering temporary, emergency, auxiliary, and stand-by service.

(17) Rules shall show any limitations on loads and cover the type of equipment which may or may not be connected.

(18) Rate-regulated utilities shall include a list of service areas and the applicable rates in such form as to facilitate ready determination of the rates available in each municipality and in such unincorporated communities as have service.

(19) Rules on meter reading, billing periods, bill issuance, timely customer payment, notice of delinquency and service disconnection for nonpayment of bill.

(20) Rules on how a customer or prospective customer should file a complaint with the utility, and how the complaint will be processed.

(21) Rules on how a customer, disconnected customer or potential customer for residential service may negotiate for a payment agreement on amount due, determination of even payment amounts, and time allowed for payments.

(22) If a sliding scale or automatic adjustment is applicable to regulated rates or charges of billed customers, the manner and method of such adjustment calculation shall be covered through a detailed explanation.

19.2(5) *Annual, periodic and other reports to be filed with the board.*

a. System map verification. A utility shall file annually with the board a verification that it has a correct set of utility system maps for each operating or distribution area. The maps shall show:

(1) Peak shaving facilities location.

(2) Feeder and distribution mains indicating size and pressure.

(3) System metering (town border stations and other supply points).

(4) Regulator stations in system indicating inlet and outlet pressures.

(5) Calorimeter location.

(6) State boundary crossing.

(7) Franchise area.

(8) Names of all communities (post offices) served.

b. Incident reports. Rescinded IAB 1/30/08, effective 3/5/08.

c. Construction programs. Rescinded IAB 11/19/97, effective 12/24/97.

d. Reports of gas service. Each utility shall compile a monthly record of gas service. The record shall be completed within 30 days after the end of the month covered. The compilation is to be kept available, for inspection by the board or its staff, at the utility's principal office within the state of Iowa. Such record shall contain:

(1) The daily and monthly average of total heating values of gas in accordance with 19.7(6).

(2) The monthly acquisition and disposition of gas.

(3) Interruptions of service occurring during the month in accordance with 19.7(7). If there were no interruptions, then it should be so stated.

(4) The number of customer pressure investigations made and the results.

(5) The number of customer meters tested and test results tabulated as follows: The number that falls into limits 0 to + 2%, + 2 to + 4%, 0 to - 2%, - 2 to - 4%, over + 4%, under - 4%, and "Does Not Register" in accuracy.

(6) Progress on leak survey programs including the number of leaks found classified as to hazard and nature, and if known, the cause and type of pipe involved.

(7) Number of district regulators checked and nature of repairs required.

(8) Number of house regulators checked and nature of repairs required.

(9) Description of any unusual operating difficulties.

(10) Type of odorant and monthly average pounds per million cubic feet used in each individual distribution system.

A summary of the 12 monthly gas service records for each calendar year shall be attached to and submitted with the utility's annual fiscal plant and statistical report to the board.

e. Filing published meter and service installation rules. A copy of the utility's current rules, if any, published or furnished by the utility for the use of engineers, architects, plumbing contractors, etc., covering meter and service installation shall be filed with the board.

f. Filing customer bill forms. A copy of each type of customer bill form in current use shall be filed with the board.

g. Reports to federal agencies. Copies of reports submitted pursuant to 49 CFR Part 191 as amended through August 19, 2009, "Transportation of Natural and Other Gas by Pipeline; Annual Reports, Incident Reports, and Safety-Related Condition Reports," shall be filed with the board. Utilities operating in other states shall provide to the board data for Iowa only.

h. Change in rate. A notification to the board shall be made of any planned change in rate of service by a utility even though the change in rate of service is provided for in its tariff filing with the board. This information shall reflect the amount of increase or decrease and the effective date of application. An up-to-date tariff sheet shall be supplied to the Iowa utilities board for its copy of the tariff showing the current rates.

i. List of persons authorized to receive board inquiries. Each utility shall file with the board in the annual report required by 199—subrule 23.1(2) a list of names, titles, addresses, and telephone numbers of persons authorized to receive, act upon, and respond to communications from the board in connection with: (1) general management duties; (2) customer relations (complaints); (3) engineering operations; (4) meter tests and repairs; (5) pipeline permits (gas). Each utility shall file with the board a telephone contact number or numbers where the board can obtain current information 24 hours a day about incidents and interruptions of service from a knowledgeable person. The contact information required by this paragraph shall be kept current as changes or corrections are made.

j. Residential customer statistics. Each rate-regulated gas utility shall file with the board on or before the fifteenth day of each month one copy of the following residential customer statistics for the preceding month:

(1) Number of accounts;

(2) Number of accounts certified as eligible for energy assistance since the preceding October 1;

(3) Number of accounts past due;

(4) Number of accounts eligible for energy assistance and past due;

(5) Total revenue owed on accounts past due;

(6) Total revenue owed on accounts eligible for energy assistance and past due;

(7) Number of disconnection notices issued;

(8) Number of disconnection notices issued on accounts eligible for energy assistance;

(9) Number of disconnections for nonpayment;

(10) Number of reconnections;

(11) Number of accounts determined uncollectible; and

(12) Number of accounts eligible for energy assistance and determined uncollectible.

k. Monthly, periodic and annual reports. Each utility shall file such other monthly, periodic and annual reports as are requested by the board. Monthly and periodic reports shall be due in the board's office within 30 days after the end of the reporting period. All annual reports shall be filed with this board by April 1 of each year for the preceding calendar year.

This rule is intended to implement Iowa Code section 476.2.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.3(476) General service requirements.

19.3(1) *Disposition of gas.* The meter and any service line pressure regulator shall be owned by the utility. The utility shall place a visible seal on all meters and service line regulators in customer use, such that the seal must be broken to gain entry.

a. All gas sold by a utility shall be on the basis of meter measurement except:

(1) Where the consumption of gas may be readily computed without metering; or

(2) For temporary service installations.

b. The amount of all gas delivered to multioccupancy premises within a single building, where units are separately rented or owned, shall be measured on the basis of individual meter measurement for each unit, except in the following instances:

(1) Where gas is used in centralized heating, cooling or water-heating systems;

(2) Where a facility is designated for elderly or handicapped persons;

(3) Where submetering or resale of service was permitted prior to 1966; or

(4) Where individual metering is impractical. "Impractical" means: (1) where conditions or structural barriers exist in the multioccupancy building that would make individual meters unsafe or physically impossible to install; (2) where the cost of providing individual metering exceeds the long-term benefits of individual metering; or (3) where the benefits of individual metering (reduced and controlled energy consumption) are more effectively accomplished through a master meter arrangement.

If a multioccupancy building is master-metered, the end-user occupants may be charged for natural gas as an unidentified portion of the rent, condominium fee, or similar payment, or, if some other method of allocating the cost of the gas service is used, the total charge for gas service shall not exceed the total gas bill charged by the utility for the same period.

c. Master metering to multiple buildings is prohibited, except for multiple buildings owned by the same person or entity. Multioccupancy premises within a multiple building complex may be master-metered pursuant to this paragraph only if the requirements of paragraph 19.3(1)*"b"* have been met.

d. For purposes of this subrule, a "master meter" means a single meter used in determining the amount of natural gas provided to a multioccupancy building or multiple buildings.

e. This rule shall not be construed to prohibit any utility from requiring more extensive individual metering than otherwise required by this rule if pursuant to tariffs filed with and approved by the board.

f. All gas consumed by the utility shall be on the basis of meter measurement except where consumption may be readily computed without metering or where metering is impractical.

19.3(2) *Condition of meter.* Rescinded IAB 11/12/03, effective 12/17/03. See 199 IAC 19.6(7).

19.3(3) *Meter reading records.* The meter reading records shall show:

a. Customer's name, address, rate schedule, or identification of rate schedule.

b. Identifying number or description of the meter(s).

c. Meter readings.

d. If the reading has been estimated.

e. Any applicable multiplier or constant, or reference thereto.

19.3(4) *Meter charts.* All charts taken from recording meters shall be marked with the initial and final date and hour of the record, the meter identification, customer's name and location and the chart multiplier.

19.3(5) *Meter register.* If it is necessary to apply a multiplier to the meter readings, the multiplier must be marked on the face of the meter register or stenciled in weather resistant paint upon the front cover of the meter. Where remote meter reading is used, whether outdoor on-premises or

off-premises-automated, the customers shall have a readable meter register at the meter as a means of verifying the accuracy of bills presented to them.

19.3(6) *Prepayment meters.* Prepayment meters shall not be geared or set so as to result in the charge of a rate or amount higher than would be paid if a standard type meter were used, except under such special rate schedule as may be filed under 19.2(4).

19.3(7) *Meter reading and billing interval.* Readings of all meters used for determining charges and billings to customers shall be scheduled at least monthly and for the beginning and termination of service. Bills to larger customers may, for good cause, be rendered weekly or daily for a period not to exceed one month. Intervals other than monthly shall not be applied to smaller customers, or to larger customers after the initial month provided above, without an exemption from the board. A waiver request must include the information required by 199—1.3(17A,474,476,78GA,HF2206). If the board denies a waiver, or if a waiver is not sought with respect to a large volume customer after the initial month, that customer's bill shall be rendered monthly for the next 12 months, unless prior approval is received from the board for a shorter interval. The group of larger customers to which shorter billing intervals may be applied shall be specified in the utility's tariff sheets, but shall not include residential customers.

An effort shall be made to obtain readings of the meters on corresponding days of each meter-reading period. The utility rules may permit the customer to supply the meter readings by telephone or on a form supplied by the utility. The utility may arrange for customer meter reading forms to be delivered to the utility by United States mail, electronically, or by hand delivery. Unless the utility has a plan to test check meter readings, a utility representative shall physically read the meter at least once each 12 months and when the utility is notified there is a change of customer.

The utility may arrange for the meter to be read by electronic means. Unless the utility has a plan to test check electronic meter readings, a utility representative shall physically read the meter at least once every 12 months.

19.3(8) *Readings and estimates.* When a customer is connected or disconnected or the meter reading date causes a given billing period to deviate by more than 10 percent (counting only business days) from the normal meter reading period, such bill shall be prorated on a daily basis.

When access to meters cannot be gained, the utility may leave with the customer a meter reading form. The customer may provide the meter reading by telephone, electronic mail (if it is allowed by the utility), or by mail. If the meter reading information is not returned in time for the billing operation, an estimated bill may be rendered. If an actual meter reading cannot be obtained, the utility may render an estimated bill without reading the meter or supplying a meter reading form to the customer. Only in unusual cases or when approval is obtained from the customer shall more than three consecutive estimated bills be rendered.

The utility shall incorporate normalized weather data in its calculation of an estimated bill.

Utilities shall file with the board their procedures for calculating estimated bills, including their procedures for determining the reasonable degree-day data to use in the calculations. Utilities shall inform the board when changes are made to the procedures for calculating estimated bills.

19.3(9) *Temporary service.* When the utility renders a temporary service to a customer it may require that the customer bear all the cost of installing and removing the service in excess of any salvage realized.

19.3(10) *Plant additions, distribution main extensions, and service lines.*

a. Definitions. The following definitions shall apply to the terms as used in this subrule.

"Advance for construction," as used in this subrule, means cash payments or equivalent surety made to the utility by an applicant for an extensive plant addition or a distribution main extension, portions of which may be refunded depending on any subsequent service line attached to the extensive plant addition or distribution main extension. Cash payments or equivalent surety shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Agreed-upon attachment period," as used in this subrule, means a period of not less than 30 days nor more than one year mutually agreed upon by the utility and the applicant within which the customer will attach. If no time period is mutually agreed upon, the agreed-upon attachment period shall be deemed to be 30 days.

"Contribution in aid of construction," as used in this subrule, means a nonrefundable cash payment grossed-up for the income tax effect of such revenue covering the costs of a distribution main extension or service line that are in excess of costs paid by the utility. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Distribution main extension," as used in this subrule, means a segment of pipeline installed to convey gas to individual service lines or other distribution mains.

"Estimated annual revenues," as used in this subrule, shall be calculated based upon the following factors, including, but not limited to: The size of the facility to be used by the customer, the size and type of equipment to be used by the customer, the average annual amount of service required by the equipment, and the average number of hours per day and days per year the equipment will be in use.

"Estimated base revenues," as used in this subrule, shall be calculated by subtracting the cost of purchased gas and energy efficiency charges from estimated annual revenues.

"Estimated construction costs," as used in this subrule, shall be calculated using average current costs in accordance with good engineering practices and upon the following factors: amount of service required or desired by the customer requesting the distribution main extension or service line; size, location, and characteristics of the distribution main extension or service line, including appurtenances; and whether the ground is frozen or whether other adverse conditions exist. In no event shall estimated construction costs include costs associated with facilities built for the convenience of the utility. The customer shall be charged actual permit fees in addition to estimated construction costs. Permit fees are to be paid regardless of whether the customer is required to pay an advance for construction or a nonrefundable contribution in aid of construction, and the cost of any permit fee is not refundable.

"Plant addition," as used in this subrule, means any additional plant, other than a distribution main or service line, required to be constructed to provide service to a customer.

"Service line," as used in this subrule, means the piping that extends from the distribution main to the meter set riser.

"Similarly situated customer," as used in this subrule, means a customer whose annual consumption or service requirements, as defined by estimated annual revenue, are approximately the same as the annual consumption or service requirements of other customers.

"Utility," as used in this subrule, means a rate-regulated utility.

b. Plant additions. The utility shall provide all gas plant at its cost and expense without requiring an advance for construction from customers or developers except in those unusual circumstances where extensive plant additions are required before the customer can be served. A written contract between the utility and the customer which requires an advance for construction by the customer to make plant additions shall be available for board inspection.

c. Distribution main extensions. Where the customer will attach to the distribution main extension within the agreed-upon attachment period after completion of the distribution main extension, the following shall apply:

(1) The utility shall finance and make the distribution main extension for a customer without requiring an advance for construction if the estimated construction costs to provide a distribution main extension are less than or equal to three times estimated base revenue calculated on the basis of similarly situated customers. The utility may use a feasibility model, rather than three times estimated base revenue, to determine what, if any, advance for construction is required of the customer. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. Whether or not the construction of the distribution main extension would otherwise require a payment from a customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(2) If the estimated construction cost to provide a distribution main extension is greater than three times estimated base revenue calculated on the basis of similarly situated customers, the applicant for a distribution main extension shall contract with the utility and make, no more than 30 days prior to commencement of construction, an advance for construction equal to the estimated construction cost less three times estimated base revenue to be produced by the customer. The utility may use a feasibility

model to determine whether an advance for construction is required. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the distribution main extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(3) Where the customer will not attach within the agreed-upon attachment period after completion of the distribution main extension, the applicant for the distribution main extension shall contract with the utility and make, no more than 30 days prior to the commencement of construction, an advance for construction equal to the estimated construction cost. The utility may use a feasibility model to determine the amount of the advance for construction. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the distribution main extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(4) Advances for construction may be paid by cash or equivalent surety and shall be refundable for ten years. The customer has the option of providing an advance for construction by cash or equivalent surety unless the utility determines that the customer has failed to comply with the conditions of a surety in the past.

(5) Refunds. When the customer is required to make an advance for construction, the utility shall refund to the depositor for a period of ten years from the date of the original advance a pro-rata share for each service line attached to the distribution main extension. The pro-rata refund shall be computed in the following manner:

1. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the distribution main extension and each service line attached to the distribution main extension exceeds the total estimated construction cost to provide the distribution main extension, the entire amount of the advance for construction shall be refunded.

2. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the distribution main extension and each service line attached to the distribution main extension is less than the total estimated construction cost to provide the distribution main extension, the amount to be refunded shall equal three times estimated base revenue, or the amount allowed by the feasibility model, when a service line is attached to the distribution main extension.

3. In no event shall the total amount to be refunded exceed the amount of the advance for construction. Any amounts subject to refund shall be paid by the utility without interest. At the expiration of the above-described ten-year period, the advance for construction record shall be closed and the remaining balance shall be credited to the respective plant account.

(6) The utility shall keep a record of each work order under which the distribution main extension was installed, to include the estimated revenues, the estimated construction costs, the amount of any payment received, and any refunds paid.

d. Service lines.

(1) The utility shall finance and construct a service line without requiring a nonrefundable contribution in aid of construction or any payment by the applicant where the length of the service line to the riser is up to 50 feet on private property or 100 feet on private property if polyethylene plastic pipe is used.

(2) Where the length of the service line exceeds 50 feet on private property or 100 feet if polyethylene plastic pipe is used, the applicant shall be required to provide a nonrefundable contribution in aid of construction, within 30 days after completion, for that portion of the service line on private property, exclusive of the riser, in excess of 50 feet or in excess of 100 feet if polyethylene plastic pipe is used. The nonrefundable contribution in aid of construction for that portion of the service line shall be computed as follows:

$$\text{(Estimated Construction Costs)} \times \frac{\text{(Total Length in Excess of 50 Feet) or (Total Length in Excess of 100 Feet)}}{\text{(Total Length of Service Line)}}$$

(3) A utility may adopt a tariff or rule that allows the utility to finance and construct a service line of more than 50 feet, or 100 feet if polyethylene plastic pipe is used, without requiring a nonrefundable contribution in aid of construction from the customer if the tariff or rule applies equally to all customers.

(4) Whether or not the construction of the service line would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees.

e. Extensions not required. Utilities shall not be required to make distribution main extensions or attach service lines as described in this subrule, unless the distribution main extension or service line shall be of a permanent nature.

f. Different payment arrangement. This subrule shall not be construed as prohibiting any utility from making a contract with a customer using a different payment arrangement, if the contract provides a more favorable payment arrangement to the customer, so long as no discrimination is practiced among customers.

19.3(11) *Cooperation and advance notice.* In order that full benefit may be derived from this chapter and in order to facilitate its proper application, all utilities shall observe the following cooperative practices:

a. Every utility shall give to other public utilities in the same general territory advance notice of any construction or change in construction or in operating conditions of its facilities concerned or likely to be concerned in situations of proximity, provided, however, that the requirements of this chapter shall not apply to routine extensions or minor changes in the local underground distribution facilities.

b. Every utility shall assist in promoting conformity with this chapter. An arrangement should be set up among all utilities whose facilities may occupy the same general territory, providing for the interchange of pertinent data and information including that relative to proposed and existing construction and changes in operating conditions concerned or likely to be concerned in situations of proximity.

This rule is intended to implement 42 U.S.C.A. §8372, 10 CFR 516.30, and Iowa Code section 476.8.
[**ARC 7584B**, IAB 2/25/09, effective 4/1/09]

199—19.4(476) Customer relations.

19.4(1) *Customer information.* Each utility shall:

a. Maintain up-to-date maps, plans or records of its entire transmission and distribution systems, with such other information as may be necessary to enable the utility to advise prospective customers, and others entitled to the information, as to the facilities available for serving customers in its service area.

b. Assist the customer or prospective customer in selecting the most economical rate schedule available for the proposed type of service.

c. Notify customers affected by a change in rates or schedule classification in the manner provided in the rules of practice and procedure before the board. (199—7.4(476)IAC)

d. Post a notice in a conspicuous place in each office of the utility where applications for service are received, informing the public that copies of the rate schedules and rules relating to the service of the utility, as filed with the board, are available for public inspection. If the utility provides access to its rate schedules and rules for service on its Web site, the notice should include the Web site address.

e. Upon request, inform its customers as to the method of reading meters.

f. State, on the bill form, that tariff and rate schedule information is available upon request at the utility's local business office.

g. Upon request, transmit a statement of either the customer's actual consumption, or degree day adjusted consumption, at the company's option, of natural gas for each billing period during the prior 12 months.

h. Furnish such additional information as the customer may reasonably request.

i. Promptly and courteously resolve inquiries for information or complaints. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer that will enable the customer to reach that employee again if needed.

Each utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)281-3839 or toll-free 1-877-565-4450, or by writing to 350 Maple Street, Des Moines, Iowa 50319, or by E-mail to iubcustomer@iub.state.ia.us."

The bill insert or notice for municipal utilities shall include the following statement: "If your complaint is related to service disconnection, safety, or renewable energy, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)281-3839, or toll-free 1-877-565-4450, by writing to 350 Maple Street, Des Moines, Iowa 50319, or by E-mail to iubcustomer@iub.state.ia.us."

The bill insert or notice on the bill shall be provided monthly by utilities serving more than 50,000 Iowa retail customers and no less than annually by all other natural gas utilities. Any utility which does not use the standard statement described in this paragraph shall file its proposed statement in its tariff for approval. A utility that bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information set forth above.

19.4(2) *Customer deposits.*

a. Each utility may require from any customer or prospective customer a deposit intended to guarantee partial payment of bills for service. Each utility shall allow a person other than the customer to pay the customer's deposit. In lieu of a cash deposit, the utility may accept the written guarantee of a surety or other responsible party as surety for an account. Upon termination of a guarantee contract, or whenever the utility deems the contract insufficient as to amount or surety, a cash deposit or a new or additional guarantee may be required for good cause upon reasonable written notice.

b. A new or additional deposit may be required from a customer when a deposit has been refunded or is found to be inadequate. Written notice shall be mailed advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of mailing to comply. The new or additional deposit shall be payable at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

c. No deposit shall be required as a condition for service other than determined by application of either credit rating or deposit calculation criteria, or both, of the filed tariff.

d. The total deposit for any residential or commercial customer for a place which has previously received service shall not be greater than the highest billing of service for one month for the place in the previous 12-month period. The deposit for any residential or commercial customer for a place which has not previously received service or for an industrial customer, shall be the customer's projected one-month usage for the place to be served as determined by the utility, or as may be reasonably required by the utility in cases involving service for short periods or special occasions.

19.4(3) *Interest on customer deposits.* Interest shall be paid by the rate-regulated utility to each customer required to make a deposit. On or after April 21, 1994, rate-regulated utilities shall compute interest on customer deposits at 7.5 percent per annum, compounded annually. Interest for prior periods shall be computed at the rate specified by the rule in effect for the period in question. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the

customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

19.4(4) *Customer deposit records.* Each utility shall keep records to show:

a. The name and address of each depositor.

b. The amount and date of the deposit.

c. Each transaction concerning the deposit.

19.4(5) *Customer's receipt for a deposit.* Each utility shall issue a receipt of deposit to each customer from whom a deposit is received, and shall provide means whereby a depositor may establish claim if the receipt is lost.

19.4(6) *Deposit refund.* A deposit shall be refunded after 12 consecutive months of prompt payment (which may be 11 timely payments and one automatic forgiveness of late payment), unless the utility is entitled to require a new or additional deposit. For refund purposes, the account shall be reviewed after 12 months of service following the making of the deposit and for each 12-month interval terminating on the anniversary of the deposit. However, deposits received from customers subject to the exemption provided by subrule 19.3(7), including surety deposits, may be retained by the utility until final billing. Upon termination of service, the deposit plus accumulated interest, less any unpaid utility bill of the customer, shall be reimbursed to the person who made the deposit.

19.4(7) *Unclaimed deposits.* The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

19.4(8) *Customer bill forms.* Each customer shall be informed as promptly as possible following the reading of the customer's meter, on bill form or otherwise, the following:

a. The reading of the meter at the beginning and at the end of the period for which the bill is rendered.

b. The dates on which the meter was read at the beginning and end of the billing period.

c. The number and kind of units metered.

d. The applicable rate schedule or identification of the applicable rate schedule.

e. The account balance brought forward and the amount of each net charge for rate-schedule-priced utility service, sales tax, other taxes, late payment charge, and total amount currently due. In the case of prepayment meters, the amount of money collected shall be shown.

f. The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is rendered.

g. A distinct marking to identify an estimated bill.

h. A distinct marking to identify a minimum bill.

i. Any conversions from meter reading units to billing units, or any calculations to determine billing units from recording or other devices, or any other factors, such as sliding scale or automatic adjustment and amount of sales tax adjustments used in determining the bill.

19.4(9) *Customer billing information alternate.* A utility serving fewer than 5000 gas customers may provide the information in 19.4(8) on bill form or otherwise. If the utility elects not to provide the information of 19.4(8) on the bill form, it shall advise the customer, on the bill form or by bill insert, that such information can be obtained by contacting the utility's local office.

19.4(10) *Payment agreements.*

a. Availability of a first payment agreement. When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to the utility for residential utility service and is not in default of a payment agreement with the utility, a utility shall offer the customer an opportunity to enter into a reasonable payment agreement.

b. Reasonableness. Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, the size of the bill, the amount of time and the reasons why the bill has been

outstanding, and any special circumstances creating extreme hardships within the household. The utility may require the person to confirm financial difficulty with an acknowledgment from the department of human services or another agency.

c. Terms of payment agreements.

(1) *First payment agreement.* The utility shall offer customers who have received a disconnection notice or have been disconnected 120 days or less and who are not in default of a payment agreement the option of spreading payments evenly over at least 12 months by paying specific amounts at scheduled times. The utility shall offer customers who have been disconnected more than 120 days and who are not in default of a payment agreement the option of spreading payments evenly over at least 6 months by paying specific amounts at scheduled times.

1. The agreement shall also include provision for payment of the current account. The agreement negotiations and periodic payment terms shall comply with tariff provisions which are consistent with these rules. The utility may also require the customer to enter into a level payment plan to pay the current bill.

2. When the customer makes the agreement in person, a signed copy of the agreement shall be provided to the customer.

3. The utility may offer the customer the option of making the agreement over the telephone or through electronic transmission. When the customer makes the agreement over the telephone or through electronic transmission, the utility shall render to the customer a written document reflecting the terms and conditions of the agreement within three days of the date the parties entered into the oral agreement or electronic agreement. The document will be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the document shall be considered rendered to the customer when delivered to the last-known address of the person responsible for payment for the service. The document shall state that unless the customer notifies the utility within ten days from the date the document is rendered, it will be deemed that the customer accepts the terms as reflected in the written document. The document stating the terms and agreements shall include the address and a toll-free or collect telephone number where a qualified representative can be reached. By making the first payment, the customer confirms acceptance of the terms of the oral agreement or electronic agreement.

4. Each customer entering into a first payment agreement shall be granted at least one late payment that is made four days or less beyond the due date for payment and the first payment agreement shall remain in effect.

(2) *Second payment agreement.* The utility shall offer a second payment agreement to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement. The second payment agreement shall be for the same term as or longer than the term of the first payment agreement. The customer shall be required to pay for current service in addition to the monthly payments under the second payment agreement and may be required to make the first payment up-front as a condition of entering into the second payment agreement. The utility may also require the customer to enter into a level payment plan to pay the current bill. The utility may offer additional payment agreements to the customer.

d. Refusal by utility. A customer may offer the utility a proposed payment agreement. If the utility and the customer do not reach an agreement, the utility may refuse the offer orally, but the utility must render a written refusal of the customer's final offer, stating the reason for the refusal, within three days of the oral notification. The written refusal shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal shall be considered rendered to the customer when handed to the customer or when delivered to the last-known address of the person responsible for the payment for the service.

A customer may ask the board for assistance in working out a reasonable payment agreement. The request for assistance must be made to the board within ten days after the rendering of the written refusal. During the review of this request, the utility shall not disconnect the service.

19.4(11) *Bill payment terms.* The bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. There shall be not less than 20 days between the rendering of a bill and the date by which the account becomes delinquent. Bills for customers on more frequent billing intervals under subrule 19.3(7) may not be considered delinquent less than 5 days from the date of rendering. However, a late payment charge may not be assessed if payment is received within 20 days of the date the bill is rendered.

a. The date of delinquency for all residential customers or other customers whose consumption is less than 250 ccf per month shall be changeable for cause in writing; such as, but not limited to, 15 days from approximate date each month upon which income is received by the person responsible for payment. In no case, however, shall the utility be required to delay the date of delinquency more than 30 days beyond the date of preparation of the previous bill.

b. In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge shall not exceed 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge. This rule does not prohibit cost-justified charges for disconnection and reconnection of service.

c. If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall be credited pro rata between the bill for utility services and related taxes.

d. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified that the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

e. Level payment plan. Utilities shall offer a level payment plan to all residential customers or other customers whose consumption is less than 250 ccf per month. A level payment plan should be designed to limit the volatility of a customer's bill and maintain reasonable account balances. The level payment plan shall include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service.

(2) Allow for entry into the level payment plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer shall be allowed the option of obtaining a refund or applying the credit to future charges. A utility is not required to offer a new level payment plan to a customer for six months after the customer has terminated from a level payment plan.

(4) Use a computation method that produces a reasonable monthly level payment amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements in 19.4(11)*"e"*(4). The computation method used by the utility shall be described in the utility's tariff and shall be subject to board approval. The utility shall give notice to customers when it changes the type of computation method in the level payment plan.

The amount to be paid at each billing interval by a customer on a level payment plan shall be computed at the time of entry into the plan and shall be recomputed at least annually. The level payment amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price, consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

When the level payment amount is recomputed, the level payment plan account balance shall be divided by 12, and the resulting amount shall be added to the estimated monthly level payment amount. Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be given the option of applying any credit to payments of subsequent months' level payment amounts due or of obtaining a refund of any credit in excess of $25.

Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be notified of the recomputed payment amount not less than one full billing cycle prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

(5) Irrespective of the account balance, a delinquency in payment shall be subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the level payment amount. If the account balance is a credit, the level payment plan may be terminated by the utility after 30 days of delinquency.

19.4(12) *Customer records.* The utility shall retain customer billing records for the length of time necessary to permit the utility to comply with 19.4(13) but not less than three years.

19.4(13) *Adjustment of bills.* Bills which are incorrect due to billing errors or faulty metering installation are to be adjusted as follows:

a. Fast metering. Whenever a metering installation is tested and found to have overregistered more than 2 percent, the utility shall recalculate the bills for service.

(1) The bills for service shall be recalculated from the time at which the error first developed or occurred if that time can be definitely determined.

(2) If the time at which the error first developed or occurred cannot be definitely determined, it shall be assumed that the overregistration has existed for the shortest time period calculated as one-half the time since the meter was installed or one-half the time elapsed since the last meter test unless otherwise ordered by the board.

(3) If the recalculated bills indicate that $5 or more is due an existing customer or $10 or more is due a person no longer a customer of the utility, the tariff shall provide for refunding of the full amount of the calculated difference between the amount paid and the recalculated amount. Refunds shall be made to the two most recent customers who received service through the metering installation during the time the error existed. In the case of a previous customer who is no longer a customer of the utility, a notice of the amount subject to refund shall be mailed to such previous customer at the last-known address, and the utility shall, upon demand made within three months thereafter, refund the same.

Refunds shall be completed within six months following the date of the metering installation test.

b. Slow metering. Whenever a meter is found to be more than 2 percent slow, the tariff may provide for back billing the customer for the amount the test indicates has been undercharged for the period of inaccuracy.

When the average error cannot be determined by test because of failure of part or all of the metering equipment, the tariff may provide for use of the registration of check metering installation, if any, or for estimating the quantity consumed based on available data. The customer must be advised of the failure and of the basis for the estimate of quantity billed.

(1) The utility may not back bill due to underregistration unless a minimum back bill amount is specified in its tariff. The minimum amount specified for back billing shall not be less than, but may be greater than, $5 for an existing customer or $10 for a former customer. All recalculations resulting in an amount due equal or greater than the tariff specified minimum shall result in issuance of a back bill.

(2) The period for back billing shall not exceed the last six months the meter was in service unless otherwise ordered by the board.

(3) Back billings shall be rendered no later than six months following the date of the metering installation test.

c. Billing adjustments due to fast or slow meters shall be calculated on the basis that the meter should be 100 percent accurate. For the purpose of billing adjustment the meter error shall be one-half of the algebraic sum of the error at full-rated flow plus the error at check flow.

d. When a customer has been overcharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter, or other similar reasons, the amount of the overcharge shall be adjusted, refunded, or credited to the customer. The time period for which the utility is required to adjust, refund, or credit the customer's bill shall not exceed five years unless otherwise ordered by the board.

e. Undercharges. When a customer has been undercharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter, or other similar reasons, the amount of the undercharge may be billed to the customer. The period for which the utility may adjust for the undercharge shall not exceed five years unless otherwise ordered by the board. The maximum back bill shall not exceed the dollar amount equivalent to the tariffed rate for like charges (e.g., usage-based, fixed or service charges) in the 12 months preceding discovery of the error unless otherwise ordered by the board.

19.4(14) *Credits and explanations.* Credits due a customer because of meter inaccuracies, errors in billing, or misapplication of rates shall be separately identified.

19.4(15) *Refusal or disconnection of service.* A utility shall refuse service or disconnect service to a customer, as defined in subrule 19.1(3), in accordance with tariffs that are consistent with these rules.

a. The utility shall give written notice of pending disconnection except as specified in paragraph 19.4(15)*"b."* The notice shall set forth the reason for the notice and final date by which the account is to be settled or specific action taken. The notice shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered rendered when delivered to the last-known address of the person responsible for payment for the service. The date for disconnection of service shall be not less than 12 days after the notice is rendered. The date for disconnection of service for customers on shorter billing intervals under subrule 19.3(7) shall not be less than 24 hours after the notice is posted at the service premises.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for disconnection of service. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes shall be concurrent.

b. Service may be disconnected without notice:

(1) In the event of a condition determined by the utility to be hazardous.

(2) In the event of customer use of equipment in a manner which adversely affects the utility's equipment or the utility's service to others.

(3) In the event of tampering with the equipment furnished and owned by the utility. For the purposes of this subrule, a broken or absent meter seal alone shall not constitute tampering.

(4) In the event of unauthorized use.

c. Service may be disconnected or refused after proper notice:

(1) For violation of or noncompliance with the utility's rules on file with the board.

(2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way which are specified to be furnished, in the utility's rules filed with the board, as conditions of obtaining service, or for the withdrawal of that same equipment, or for the termination of those same permissions or rights, or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the board.

(3) For failure of the customer to permit the utility reasonable access to the utility's equipment.

d. Service may be refused or disconnected after proper notice for nonpayment of a bill or deposit, except as restricted by subrules 19.4(16) and 19.4(17), provided that the utility has complied with the following provisions when applicable:

(1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal;

(2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities available. Customers billed more frequently than monthly pursuant to subrule 19.3(7) shall be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices shall include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each

utility representative must provide the representative's name and have immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.

(3) The summary of the rights and responsibilities must be approved by the board. Any utility providing gas service and defined as a public utility in Iowa Code section 476.1 which does not use the standard form set forth below for customers billed monthly shall submit to the board an original and six copies of its proposed form for approval. A utility billing a combination customer for both gas and electric service may modify the standard form to replace each use of the word "gas" with the words "gas and electric" in all instances.

CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF OF GAS SERVICE FOR NONPAYMENT

1. What can I do if I receive a notice from the utility that says my gas service will be shut off because I have a past due bill?

a. Pay the bill in full; or

b. Enter into a reasonable payment plan with the utility (see #2 below); or

c. Apply for and become eligible for low-income energy assistance (see #3 below); or

d. Give the utility a written statement from a doctor or public health official stating that shutting off your gas service would pose an especial health danger for a person living at the residence (see #4 below); or

e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

2. How do I go about making a reasonable payment plan? (Residential customers only)

a. Contact the utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, the utility may offer you a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.

b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.

c. If you do not make the payments you promise, the utility may shut off your utility service on one day's notice unless all the money you owe the utility is paid or you enter into another payment agreement.

3. How do I apply for low-income energy assistance? (Residential customers only)

a. Contact the local community action agency in your area (see attached list); or

b. Contact the Division of Community Action Agencies at the Iowa Department of Human Rights, Lucas State Office Building, Des Moines, Iowa 50319; telephone (515)281-0859. To prevent disconnection, you must contact the utility prior to disconnection of your service.

c. To avoid disconnection, you must apply for energy assistance before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

d. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1.

4. What if someone living at the residence has a serious health condition? (Residential customers only)

Contact the utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your utility service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the utility office within 5 days of when your doctor or public health official notifies the utility of the health condition; otherwise, your utility service may be shut off. If the utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if payment arrangements have not been made.

5. What should I do if I believe my bill is not correct?

You may dispute your utility bill. You must tell the utility that you dispute the bill. You must pay the part of the bill you think is correct. If you do this, the utility will not shut off your service for 45 days from the date the bill was mailed while you and the utility work out the dispute over the part of the

bill you think is incorrect. You may ask the Iowa Utilities Board for assistance in resolving the dispute. (See #9 below.)

6. When can the utility shut off my utility service because I have not paid my bill?

a. Your utility can shut off service between the hours of 6 a.m. and 2 p.m., Monday through Friday.

b. The utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.

c. The utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).

d. The utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.

e. If you have qualified for low-income energy assistance, the utility cannot shut off your service from November 1 through April 1. However, you will still owe the utility for the service used during this time.

f. The utility will not shut off your service if you have notified the utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

7. How will I be told the utility is going to shut off my gas service?

a. You must be given a written notice at least 12 days before the utility service can be shut off for nonpayment. This notice will include the reason for shutting off your service.

b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.

c. The utility must also try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the utility cannot reach you by telephone or in person, the utility will put a written notice on the door of your residence to tell you that your utility service will be shut off.

8. If service is shut off, when will it be turned back on?

a. The utility will turn your service back on if you pay the whole amount you owe or agree to a reasonable payment plan (see #2 above).

b. If you make your payment during regular business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after regular business hours, the utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility must do it by 11 a.m. the next day.

c. The utility may charge you a fee to turn your service back on. Those fees may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

9. Is there any other help available besides my utility?

If the utility has not been able to help you with your problem, you may contact the Iowa Utilities Board toll-free at 1-877-565-4450. You may also write the Iowa Utilities Board at 350 Maple Street, Des Moines, Iowa 50319-0069, or by E-mail at iubcustomer@iub.state.ia.us. Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid, and may contact Legal Aid at 1-800-532-1275.

(4) When disconnecting service to a residence, made a diligent attempt to contact, by telephone or in person, the customer responsible for payment for service to the residence to inform the customer of the pending disconnection and the customer's rights and responsibilities. During the period from November 1 through April 1, if the attempt at customer contact fails, the premises shall be posted at least one day prior to disconnection with a notice informing the customer of the pending disconnection and rights and responsibilities available to avoid disconnection.

If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the landlord of the rental unit, if known, shall be contacted to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord shall also be informed of the date when service may be disconnected.

If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the utility to contain residential units affected by disconnection must be posted,

at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

(5) Disputed bill. If the customer has received notice of disconnection and has a dispute concerning a bill for natural gas service, the utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of service. A utility shall delay disconnection for nonpayment of the disputed bill for up to 45 days after the rendering of the bill if the customer pays the undisputed amount. The 45 days shall be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board in compliance with 199—Chapter 6.

(6) Reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable efforts shall be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts shall be made to reconnect the customer not later than 11 a.m. the next day.

(7) Severe cold weather. A disconnection may not take place where gas is used as the only source of space heating or to control or operate the only space heating equipment at the residence on any day when the National Weather Service forecast for the following 24 hours covering the area in which the residence is located includes a forecast that the temperature will be 20 degrees Fahrenheit or colder. In any case where the utility has posted a disconnect notice in compliance with subparagraph 19.4(15)*"d"*(4) but is precluded from disconnecting service because of a National Weather Service forecast, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the area where the residence is located rises above 20 degrees Fahrenheit and is forecasted to be above 20 degrees Fahrenheit for at least 24 hours, unless the customer has paid in full the past due amount or is entitled to postponement of disconnection under some other provision of paragraph 19.4(15)*"d."*

(8) Health of a resident. Disconnection of a residential customer shall be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises. An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to: age, infirmity, or mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances which indicate a severe or hazardous health situation.

The utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

Verification shall postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period that the unpaid balance is to be retired, the customer is subject to disconnection pursuant to paragraph 19.4(15)*"f."*

(9) Winter energy assistance (November 1 through April 1). If the utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, there shall be no disconnection of service for 30 days from the date the utility is notified to allow the customer time to obtain assistance. Disconnection shall not take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the public utility by the community action agency as eligible for either the low-income home energy assistance program or weatherization assistance program.

e. Abnormal gas consumption. A customer who is subject to disconnection for nonpayment of bill, and who has gas consumption which appears to the customer to be abnormally high, may request the utility to provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. The utility shall provide assistance by discussing patterns of gas usage which may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance which may be available to the customer.

f. A utility may disconnect gas service without the written 12-day notice for failure of the customer to comply with the terms of a payment agreement, except as provided in numbered paragraph 19.4(10)*"c"*(1)"4," provided the utility complies with the provisions of paragraph 19.4(15)*"d."*

g. The utility shall, prior to November 1, mail customers a notice describing the availability of winter energy assistance funds and the application process. The notice must be of a type size that is easily legible and conspicuous and must contain the information set out by the state agency administering the assistance program. A utility serving fewer than 25,000 customers may publish the notice in a customer newsletter in lieu of mailing. A utility serving fewer than 6,000 customers may publish the notice in an advertisement in a local newspaper of general circulation or shopper's guide.

19.4(16) *Insufficient reasons for denying service.* The following shall not constitute sufficient cause for refusal of service to a customer:

a. Delinquency in payment for service by a previous occupant of the premises to be served.

b. Failure to pay for merchandise purchased from the utility.

c. Failure to pay for a different type or class of public utility service.

d. Failure to pay the bill of another customer as guarantor thereof.

e. Failure to pay the back bill rendered in accordance with paragraph 19.4(13)*"b"* (slow meters).

f. Failure to pay adjusted bills based on the undercharges set forth in paragraph 19.4(13)*"e."*

g. Failure of a residential customer to pay a deposit during the period November 1 through April 1 for the location at which the customer has been receiving service.

h. Delinquency in payment for service by an occupant, if the customer applying for service is creditworthy and able to satisfy any deposit requirements.

19.4(17) *When disconnection prohibited.* No disconnection may take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the public utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

19.4(18) *Change in character of service.* The following shall apply to a material change in the character of gas service:

a. Changes under the control of the utility. The utility shall make such changes only with the approval of the board, and after adequate notice to the customers (see 19.7(6)*"a"*).

b. Changes not under control of the utility or customer. The utility shall adjust appliances to attain the proper combustion of the gas supplied. Due consideration shall be given to the gas heating value and specific gravity (see 19.7(6)*"b"*).

c. Appliance adjustment charge. The utility shall make any necessary adjustments to the customer's appliances without charge and shall conduct the adjustment program with a minimum of inconvenience to the customers.

19.4(19) *Customer complaints.* Each utility shall investigate promptly and thoroughly and keep a record of written complaints and all other reasonable complaints received by it from its customers in regard to safety, service, or rates, and the operation of its system as will enable it to review and analyze its procedures and actions. The record shall show the name and address of the complainant, the date and nature of the complaint, and its disposition and the date thereof. All complaints caused by a major outage or interruption shall be summarized in a single report.

a. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of customer complaints.

b. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

c. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

This rule is intended to implement Iowa Code sections 476.2, 476.6, 476.8, 476.20 and 476.54.

199—19.5(476) Engineering practice.

19.5(1) *Requirement for good engineering practice.* The gas plant of the utility shall be constructed, installed, maintained and operated in accordance with accepted good engineering practice in the gas industry to assure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

19.5(2) *Standards incorporated by reference.*

a. The design, construction, operation, and maintenance of gas systems and liquefied natural gas facilities shall be in accordance with the following standards where applicable:

(1) 49 CFR Part 191, "Transportation of Natural and Other Gas by Pipeline; Annual Reports, Incident Reports, and Safety-Related Condition Reports," as amended through August 19, 2009.

(2) 49 CFR Part 192, "Transportation of Natural and Other Gas by Pipeline: Minimum Federal Safety Standards," as amended through August 19, 2009.

(3) 49 CFR Part 193, "Liquefied Natural Gas Facilities: Federal Safety Standards," as amended through August 19, 2009.

(4) 49 CFR Part 199, "Drug and Alcohol Testing," as amended through August 19, 2009.

(5) ASME B31.8 - 2007, "Gas Transmission and Distribution Piping Systems."

(6) NFPA 59-2008, "Utility LP-Gas Plant Code."

(7) At railroad crossings, 199 IAC 42.7(476), "Engineering standards for pipelines."

b. The following publications are adopted as standards of accepted good practice for gas utilities:

(1) ANSI Z223.1/NFPA 54-2009, "National Fuel Gas Code."

(2) NFPA 501A-2009, "Standard for Fire Safety Criteria for Manufactured Home Installations, Sites, and Communities."

19.5(3) *Adequacy of gas supply.* The natural gas regularly available from supply sources supplemented by production or storage capacity must be sufficiently large to meet all reasonable demands for firm gas service.

19.5(4) *Gas transmission and distribution facilities.* The utility's gas transmission and distribution facilities shall be designed, constructed and maintained as required to reliably perform the gas delivery burden placed upon them. Each utility shall be capable of emergency repair work on a scale consistent with its scope of operation and with the physical conditions of its transmission and distribution facilities.

In appraising the reliability of the utility's transmission and distribution system, the board will consider, as principal factors, the condition of the physical property and the size, training, supervision, availability, equipment and mobility of the maintenance forces.

19.5(5) *Inspection of gas plant.* Each utility shall adopt a program of inspection of its gas plant in order to determine the necessity for replacement and repair. The frequency of the various inspections shall be based on the utility's experience and accepted good practice. Each utility shall keep sufficient records to give evidence of compliance with its inspection program.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.6(476) Metering.

19.6(1) *Inspection and testing program.* Each utility shall adopt a written program for the inspection and testing of its meters to determine the necessity for adjustment, replacement or repair. The frequency of inspection and methods of testing shall be based on the utility's experience, manufacturer's recommendations, and accepted good practice. The board considers the publications listed in 19.6(3) to be representative of accepted good practice. Each utility shall maintain inspection and testing records for each meter and associated device until three years after its retirement.

19.6(2) *Program content.* The written program shall, at minimum, address the following subject areas:

a. Classification of meters by capacity, type, and any other factor considered pertinent.

b. Checking of new meters for acceptable accuracy before being placed in service.

c. Testing of in-service meters, including any associated instruments or corrective devices, for accuracy, adjustments or repairs. This may be accomplished by periodic tests at specified intervals or on the basis of a statistical sampling plan, but shall include meters removed from service for any reason.

d. Periodic calibration or testing of devices or instruments used by the utility to test meters.

e. Leak testing of meters before return to service.

f. The limits of meter accuracy considered acceptable by the utility.

g. The nature of meter and meter test records maintained by the utility.

19.6(3) *Accepted good practice.* The following publications are considered to be representative of accepted good practice in matters of metering and meter testing:

a. American National Standard for Gas Displacement Meters (500 Cubic Feet Per Hour Capacity and Under), ANSI B109.1-2000.

b. American National Standard for Diaphragm Type Gas Displacement Meters (Over 500 Cubic Feet Per Hour Capacity), ANSI B109.2-2000.

c. American National Standard for Rotary Type Gas Displacement Meters, ANSI B109.3-2000.

d. Measurement of Gas Flow by Turbine Meters, ANSI/ASME MFC-4M-1986 (Reaffirmed 2008).

e. Orifice Metering of Natural Gas and Other Related Hydrocarbon Fluids, API MPMS Chapter 14.3, Parts 1-4.

19.6(4) *Meter adjustment.* All meters and associated metering devices shall, when tested, be adjusted as closely as practicable to the condition of zero error.

19.6(5) *Request tests.* Upon request by a customer, a utility shall test the meter servicing that customer. A test need not be made more frequently than once in 18 months.

A written report of the test results shall be mailed to the customer within ten days of the completed test and a record of each test shall be kept on file at the utility's office. The utility shall give the customer or a representative of the customer the opportunity to be present while the test is conducted.

If the test finds the meter is accurate within the limits accepted by the utility in its meter inspection and testing program, the utility may charge the customer $25 or the cost of conducting the test, whichever is less. The customer shall be advised of any potential charge before the meter is removed for testing.

19.6(6) *Referee tests.* Upon written request by a customer or utility, the board will conduct a referee test of a meter. A test need not be made more frequently than once in 18 months. The customer request shall be accompanied by a $30 deposit in the form of a check or money order made payable to the utility.

Within 5 days of receipt of the written request and payment, the board shall forward the deposit to the utility and notify the utility of the requirement for a test. The utility shall, within 30 days after notification of the request, schedule the date, time and place of the test with the board and customer. The meter shall not be removed or adjusted before the test. The utility shall furnish all testing equipment and facilities for the test. If the tested meter is found to be more than 2 percent fast or 2 percent slow, the deposit will be returned to the party requesting the test and billing adjustments shall be made as required in 19.4(13). The board shall issue its report within 15 days after the test is conducted, with a copy to the customer and the utility.

19.6(7) *Condition of meter.* No meter that is known to be mechanically defective, has an incorrect correction factor, or has not been tested and adjusted, if necessary, in accordance with 19.6(2)*"b," "c,"* and *"e,"* shall be installed or continued in service. The capacity of the meter and the index mechanism shall be consistent with the gas requirements of the customer.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.7(476) Standards of quality of service.

19.7(1) *Purity requirements.* All gas supplied to customers shall be substantially free of impurities which may cause corrosion of mains or piping or from corrosive or harmful fumes when burned in a properly designed and adjusted burner.

19.7(2) *Pressure limits.* The maximum allowable operating pressure for a low-pressure distribution system shall not be so high as to cause the unsafe operation of any connected and properly adjusted low-pressure gas-burning equipment.

19.7(3) *Adequacy for pressure.* Each utility shall have a substantially accurate knowledge of the pressures inside its piping. Periodic pressure measurements shall be taken during periods of high demand at remote locations in distribution systems to determine the adequacy of service. Records of such measurements including the date, time, and location of the measurement shall be maintained not less than two years.

19.7(4) *Standards for pressure measurements.*

a. Secondary standards. Each utility shall own or have access to a dead weight tester. This instrument must be maintained in an accurate condition.

b. Working standards. Each utility must have or have access to water manometers, laboratory quality indicating pressure gauges, and field-type dead weight pressure gauges as necessary for the proper testing of the indicating and recording pressure gauges used in determining the pressure on the utility's system. Working standards must be checked periodically by comparison with a secondary standard.

19.7(5) *Handling of standards.* Extreme care must be exercised in the handling of standards to ensure that their accuracy is not disturbed. Each standard shall be accompanied at all times by a certificate or calibration card, duly signed and dated, on which are recorded the corrections required to compensate for errors found at the customary test points at the time of the last previous test.

19.7(6) *Heating value.*

a. Awareness. Each utility shall have a substantially accurate knowledge of the heating value of the gas being delivered to customers at all times.

b. Natural and LP-gas. The heating value of natural gas and undiluted, commercially pure LP-gas shall be considered as being not under the control of the utility. The utility shall determine the allowable range of monthly average heating values within which its customers' appliances may be expected to function properly without repeated readjustment of the burners. If the monthly average heating value is above or below the limits of the allowable range for three successive months, the customers' appliances must be readjusted in accordance with 19.4(18)*"c."*

c. Peak shaving or other mixed gas. The heating value of gas in a distribution system which includes gas from LP or LNG peak shaving facilities, or gas from a source other than a pipeline supplier, shall be considered within the control of the utility. The average daily heating value of mixed gas shall be at least 95 percent of that normally delivered by the pipeline supplier. All mixed gas shall have a specific gravity of less than 1.000, and heating value shall not be so high as to cause improper operation of properly adjusted customer equipment.

d. Heating value determination and records. Unless acceptable heating value information is available for all periods from other sources, including the pipeline supplier, the utility shall provide and maintain equipment, or shall have a method of computation, by which the heating value of the gas in a distribution system can be accurately determined. The type, accuracy, operation and location of equipment, and the accuracy of computation methods, shall be in accordance with accepted industry practices and equipment manufacturer's recommendations and shall be subject to review by the board.

19.7(7) *Interruptions of service.*

a. Each utility shall make reasonable efforts to avoid interruptions of service, but when interruptions occur, service shall be reestablished within the shortest time practicable, consistent with safety. Each utility shall maintain records for not less than two years of interruptions of service as required to be reported in 19.17(1) and shall periodically review these records to determine steps to be taken to prevent recurrence.

b. Planned interruptions shall be made at a time that will not cause unreasonable inconvenience to customers. Interruptions shall be preceded by adequate notice to those who will be affected.

199—19.8(476) Safety.

19.8(1) *Acceptable standards.* As criteria of accepted good safety practice the board will use the applicable provisions of the standard listed in 19.5(2).

19.8(2) *Protective measures.* Each utility shall exercise reasonable care to reduce hazards inherent in connection with utility service to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public, fitted to the size and type of its operations. The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents. Each utility shall maintain a summary of all reportable accidents arising from its operations.

19.8(3) *Turning on gas.* Each utility upon the installation of a meter and turning on gas or the act of turning on gas alone shall take the necessary steps to assure itself that there exists no flow of gas through the meter which is a warning that the customer's piping or appliances are not safe for gas turn on (Ref: Sec. 8.2.3 and Annex D, ANSI Z223.1/NFPA 54-2009).

19.8(4) *Gas leaks.* A report of a gas leak shall be considered as an emergency requiring immediate attention.

19.8(5) *Odorization.* Any gas distributed to customers through gas mains or gas services or used for domestic purposes in compressor plants, which does not naturally possess a distinctive odor to the extent that its presence in the atmosphere is readily detectable at all gas concentrations of one-fifth of the lower explosive limit and above, shall have an odorant added to it to make it so detectable. Odorization is not necessary, however, for such gas as is delivered for further processing or use where the odorant would serve no useful purpose as a warning agent. Suitable tests must be made to determine whether the odor meets the standards of subrule 19.5(2). Prompt remedial action shall be taken if odorization levels do not meet the prescribed limits for detectability.

19.8(6) *Burial near electric lines.* Each pipeline shall be installed with at least 12 inches of clearance from buried electrical conductors. If this clearance cannot be maintained, protection from damage or introduction of current from an electrical fault shall be provided by other means.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—19.9(476) Energy conservation strategies. Rescinded IAB 11/12/03, effective 12/7/03.

199—19.10(476) Purchased gas adjustment (PGA).

19.10(1) *Purchased gas adjustment clause.* Purchased gas adjustments shall be computed separately for each customer classification or grouping previously approved by the board. Purchased gas adjustments shall use the same unit of measure as the utility's tariffed rates. Purchased gas adjustments shall be calculated using factors filed in annual or periodic filings according to the following formula:

$$PGA = \frac{(C \times Rc) + (D \times Rd) + (Z \times Rz)}{S} + Rb + E$$

PGA is the purchased gas adjustment per unit.

S is the anticipated yearly gas commodity sales volume for each customer classification or grouping.

C is the volume of applicable commodity purchased or transported for each customer classification or grouping required to meet sales, S, plus the expected lost and unaccounted for volumes.

Rc is the weighted average of applicable commodity prices or rates, including appropriate hedging tools costs, to be in effect September 1 corresponding to purchases C.

D is the total volume of applicable entitlement reservation purchases required to meet sales, S, for each customer classification or grouping.

Rd is the weighted average of applicable entitlement reservation charges to be in effect September 1 corresponding to purchases D.

Z is the total quantity of applicable storage service purchases required to meet sales, S, for each customer classification or grouping.

Rz is the weighted average of applicable storage service rates to be in effect September 1 corresponding to purchases Z.

Rb is the adjusted amount necessary to obtain the anticipated balance for the remaining PGA year calculated by taking the anticipated PGA balance divided by the forecasted volumes, including storage, for one or more months of the remaining PGA year.

E is the per unit overcollection or undercollection adjustment as calculated under subrule 19.10(7).

The components of the formula shall be determined as follows for each customer classification or grouping:

a. The actual sales volumes S for the prior 12-month period ending May 31, with the necessary degree-day adjustments, and further adjustments approved by the board.

Unless a utility receives prior board approval to use another methodology, a utility shall use the same weather normalization methodology used in prior approved PGA and rate case.

b. The annual expected lost and unaccounted for factors shall be calculated by determining the actual difference between sales and purchase volumes for the 12 months ending May 31 or from the current annual IG-1 filing, but in no case will this factor be less than 0.

c. The purchases C, D, and Z which will be necessary to meet requirements as determined in 19.10(1).

d. The purchased gas adjustments shall be adjusted prospectively to reflect the final decision issued by the board in a periodic review proceeding.

19.10(2) *Annual purchased gas adjustment filing.* Each rate-regulated utility shall file on or before August 1 of each year, for the board's approval, a purchased gas adjustment for the 12-month period beginning September 1 of that year.

The annual filing shall restate each factor of the formula stated in subrule 19.10(1).

The annual filing shall be based on customer classifications and groupings previously approved by the board unless new classifications or groupings are proposed.

The annual filing shall include all worksheets and detailed supporting data used to determine the purchased gas adjustment volumes and factors. The utility shall provide an explanation of the calculations of each factor. Information already on file with the board may be incorporated by reference in the filing.

19.10(3) *Periodic changes to purchased gas adjustment clause.* Periodic purchased gas adjustment filings shall be based on the purchased gas adjustment customer classifications and groupings previously approved by the board. Changes in the customer classification and grouping on file are not automatic and require prior approval by the board.

Periodic filings shall include all worksheets and detailed supporting data used to determine the amount of the adjustment.

Changes in factors S or C may not be made in periodic purchased gas filings. A change in factor D or Z may be made in periodic filings and will be deemed approved if it conforms to the annual purchased gas filing or if it conforms to the principles set out in 19.10(6).

The utility shall implement automatically all purchased gas adjustment changes which result from changes in Rc, Rd, or Rz with concurrent board notification with adequate information to calculate and support the change. The purchased gas adjustment shall be calculated separately for each customer classification or grouping.

Unless otherwise ordered by the board, a rate-regulated utility's purchased gas adjustment rate factors shall be adjusted as purchased gas costs change and shall recover from the customers only the actual costs of purchased gas and other currently incurred charges associated with the delivery, inventory, or reservation of natural gas. Such periodic changes shall become effective with usage on or after the date of change.

19.10(4) *Factor Rb.* Each utility has the option of filing an Rb calculation with its October-January PGA filings but shall file an Rb calculation with its February filing and subsequent monthly filings in the PGA year. If the anticipated PGA balance represents costs in excess of revenues, factor Rb shall be assigned a positive value; if the anticipated balance represents revenues in excess of costs, factor Rb shall be assigned a negative value.

19.10(5) *Take-or-pay adjustment.* Rescinded IAB 11/12/03, effective 12/17/03.

19.10(6) *Allocations of changes in contract pipeline transportation capacity obligations.* Any change in contractual pipeline transportation capacity obligations to transportation or storage service providers serving Iowa must be reported to the board within 30 days of receipt. The change must be applied on a pro-rata basis to all customer classifications or groupings, unless another method has been approved by the board. Where a change has been granted as a result of the utility's request based on the

needs of specified customers, that change may be allocated to the specified customers. Where the board has approved anticipated sales levels for one or more customer classifications or groupings, those levels may limit the pro-rata reduction for those classifications or groupings.

19.10(7) *Reconciliation of underbillings and overbillings.* The utility shall file with the board on or before October 1 of each year a purchased gas adjustment reconciliation for the 12-month period which began on September 1 of the previous year. This reconciliation shall be the actual net invoiced costs of purchased gas and appropriate financial hedging tools costs less the actual revenue billed through its purchased gas adjustment clause net of the prior year's reconciliation dollars for each customer classification or grouping. Actual net costs for purchased gas shall be the applicable invoice costs from all appropriate sources associated with the time period of usage.

Negative differences in the reconciliation shall be considered overbilling by the utility and positive differences shall be considered underbilling. This reconciliation shall be filed with all worksheets and detailed supporting data for each particular purchased gas adjustment clause. Penalty purchases shall only be includable where the utility clearly demonstrates a net savings.

a. The annual reconciliation filing shall include the following information concerning the hedging tools used by the utility:

(1) The type and volume of physical gas being hedged.

(2) The reason the hedge was undertaken (e.g., to hedge storage gas, a floating price contract).

(3) A detailed explanation of the hedging strategy (e.g., costless collar, straddled costless collar, purchasing or selling options).

(4) The date the futures contract or option was purchased or the date the swap was entered into.

(5) The spot price of gas at the time the hedge was made, including an explanation of how the spot price was determined including the index or indices used.

(6) The amount of all commissions paid and to whom those payments were made.

(7) All administrative costs associated with the hedge.

(8) The name(s) of all marketers used and the amount of money paid to each marketer.

(9) The amount of savings or costs resulting from the hedge.

(10) The amount of money tied up in margin accounts for futures trading and the cost of that money.

(11) The premium paid for each option.

(12) The strike price of each option.

(13) The contracting costs for each swap transaction.

(14) The name of the fixed-price payer in a swap transaction.

(15) A statement as to how the hedge is consistent with the LDC's natural gas procurement plan.

(16) An explanation as to why the LDC believes the hedge was in the best interest of general system customers.

(17) All invoices, work papers, and internal reports associated with the hedge.

b. Any underbilling determined from the reconciliation shall be collected through ten-month adjustments to the appropriate purchased gas adjustment. The underbilling generated from each purchased gas adjustment clause shall be divided by the anticipated sales volumes for the prospective ten-month period beginning November 1 (based upon the sales determination in subrule 19.10(1)).

The quotient, determined on the same basis as the utility's tariff rates, shall be added to the purchased gas adjustment for the prospective ten-month period beginning November 1.

c. Any overbilling determined from the reconciliation shall be refunded to the customer classification or grouping from which it was generated. The overbilling shall be divided by the annual cost of purchased gas subject to recovery for the 12-month period which began the prior September 1 for each purchased gas adjustment clause and applied as follows:

(1) If the net overbilling from the purchased gas adjustment reconciliation exceeds 3 percent of the annual cost of purchased gas subject to recovery for a specific customer classification or grouping, the utility shall refund the overbilling by bill credit or check starting on the first day of billing in the November billing cycle of the current year. The minimum amount to be refunded by check shall be $10. Interest shall be calculated on amounts exceeding 3 percent from the PGA year midpoint to the date of refunding. The interest rate shall be the dealer commercial paper rate (90-day, high-grade unsecured

notes) quoted in the "Money Rates" section of the Wall Street Journal on the last working day of August of the current year.

(2) If the net overbilling from the purchased gas adjustment reconciliation does not exceed 3 percent of the annual cost of purchased gas subject to recovery for a specific customer classification or grouping, the utility may refund the overbilling by bill credit or check starting on the first day of billing in the November billing cycle of the current year, or the utility may refund the overbilling through ten-month adjustments to the particular purchased gas adjustment from which they were generated. The minimum amount to be refunded by check shall be $10. This adjustment shall be determined by dividing the overcollection by the anticipated sales volume for the prospective ten-month period beginning November 1 as determined in subrule 19.10(1) for the applicable purchased gas adjustment clause. The quotient, determined on the same basis as the utility's tariff rates, shall be a reduction to that particular purchased gas adjustment for the prospective ten-month period beginning November 1.

d. When a customer has reduced or terminated system supply service and is receiving transportation service, any liability for overcollections and undercollections shall be determined in accordance with the utility's gas transportation tariff.

19.10(8) *Refunds related to gas costs charged through the PGA.* The utility shall file a refund plan with the board within 30 days of the receipt of any refund related to gas costs charged through the PGA.

a. The utility shall refund to customers by bill credit or check an amount equal to any refund, plus accrued interest, if the refund exceeds $10 per average residential customer under the applicable customer classification or grouping. The utility may refund lesser amounts through the applicable customer classification or grouping or retain undistributed refund amounts in special refund retention accounts for each customer classification or grouping under the applicable PGA clause until such time as additional refund obligations or interest cause the average residential customer refund to exceed $10. Any obligations remaining in the retention accounts on September 1 shall become a part of the annual PGA reconciliation.

b. The utility shall file with the refund plan the following information:

(1) A statement of reason for the refund.

(2) The amount of the refund with support for the amount.

(3) The balance of the appropriate refund retention accounts.

(4) The amount due under each customer classification or grouping.

(5) The intended period of the refund distribution.

(6) The estimated interest accrued for each refund through the proposed refund period, with complete interest calculations and supporting data as determined in paragraph 19.10(8)*"d."*

(7) The total amount to be refunded, the amount to be refunded per customer classification or grouping, and the refund per ccf or therm.

(8) The estimated interest accrued for each refund received and for each amount in the refund retention accounts through the date of the filing with the complete interest calculation and support as determined in paragraph 19.10(8)*"d."*

(9) The total amount to be retained, the amount to be retained per customer classification or grouping, and the level per ccf or therm.

(10) The calculations demonstrating that the retained balance is less than $10 per average residential customer with supporting schedules for all factors used.

c. The refund to each customer shall be determined by dividing the amount in the appropriate refund retention account, including interest, by the total ccf or therm of system gas consumed by affected customers during the period for which the refundable amounts are applicable and multiplying the quotient by the ccf or therms of system supply gas actually consumed by the customer during the appropriate period. The utility may use the last available 12-month period if the use of the actual period generating the refund is impractical. The utility shall file complete support documentation for all figures used.

d. The interest rate on refunds distributed under this subrule, compounded annually, shall be the dealer commercial paper rate (90-day, high-grade unsecured notes) quoted in the "Money Rates" section of the Wall Street Journal on the day the refund obligation vests. Interest shall accrue from the date the

rate-regulated utility receives the refund or billing from the supplier or the midpoint of the first month of overcollection to the date the refund is distributed to customers.

e. The rate-regulated utility shall make a reasonable effort to forward refunds, by check, to eligible recipients who are no longer customers.

f. The minimum amount to be refunded by check shall be $5.

This rule is intended to implement Iowa Code section 476.6(11).

199—19.11(476) Periodic review of gas procurement practices [476.6(15)].

19.11(1) *Procurement plan.* The board shall periodically conduct a contested case proceeding for the purpose of evaluating the reasonableness and prudence of a rate-regulated public utility's natural gas procurement and contracting practices. The board shall provide the utilities 90 days' notice of the requirement to file a procurement plan. In the years in which the board does not conduct a contested case proceeding, the board may require the utilities to file certain information for the board's review. In years in which the board conducts a full proceeding, a rate-regulated utility shall file prepared direct testimony and exhibits in support of a detailed 12-month plan and a 3-year natural gas procurement plan. A utility's procurement plan shall be organized as follows and shall include:

a. An index of all documents and information filed in the plan and identification of the board files in which documents incorporated by reference are located.

b. All contracts and gas supply arrangements executed or in effect for obtaining gas and all supply arrangements planned for the future 12-month and 3-year periods.

c. An organizational description of the officer or division responsible for gas procurement and a summary of operating procedures and policies for procuring and evaluating gas contracts.

d. A summary of the legal and regulatory actions taken to minimize purchased gas costs.

e. All studies or investigation reports considered in gas purchase contract or arrangement decisions during the plan periods.

f. A complete list of all contracts executed since the last procurement review.

g. A list of other unbundled services available (for example, storage services if offered).

h. A description of the supply options selected and an evaluation of the reasonableness and prudence of its decisions. This evaluation should show the relationship between forecast and procurement.

19.11(2) *Gas requirement forecast.* Rescinded IAB 4/3/91, effective 3/15/91.

19.11(3) *Annual review proceeding.* Rescinded IAB 2/9/00, effective 3/15/00.

19.11(4) *Evaluation of the plan.* The burden shall be on the utility to prove it is taking all reasonable actions to minimize its purchased gas costs. The board will evaluate the reasonableness and prudence of the gas procurement plan.

19.11(5) *Disallowance of costs.* The board shall disallow any purchased gas costs in excess of costs incurred under responsible and prudent policies and practices. The PGA factor shall be adjusted prospectively to reflect the disallowance.

19.11(6) *Executive summary.* On or before August 1, 2003, each natural gas utility shall file an executive summary and index of all standard and special contracts in effect for the purchase, sale or interchange of gas. On or before August 1 each year thereafter, each natural gas utility shall file an update of the executive summary and index showing the standard and special contracts in effect on that date for the purchase, sale or interchange of gas. The executive summary shall include the following information:

a. The contract number;

b. The start and end date;

c. The parties to the contract;

d. The total estimated dollar value of the contract;

e. A description of the type of service offered (including volumes and price).

This rule is intended to implement Iowa Code section 476.6(15).

199—19.12(476) Flexible rates.

19.12(1) *Purpose.* This subrule is intended to allow gas utility companies to offer, at their option, incentive or discount rates to their sales and transportation customers.

19.12(2) *General criteria.*

a. Natural gas utility companies may offer discounts to individual customers, to selected groups of customers, or to an entire class of customer. However, discounted rates must be offered to all directly competing customers in the same service territory. Customers are direct competitors if they make the same end product (or offer the same service) for the same general group of customers. Customers that only produce component parts of the same end product are not directly competing customers.

b. In deciding whether to offer a specific discount, the utility shall evaluate the individual customer's, group's, or class's situation and perform a cost-benefit analysis before offering the discount.

c. Any discount offered should be such as to significantly affect the customer's or customers' decision to stay on the system or to increase consumption.

d. The consequences of offering the discount should be beneficial to all customers and to the utility. Other customers should not be at risk of loss as a result of these discounts; in addition, the offering of discounts shall in no way lead to subsidization of the discounted rates by other customers in the same or different classes.

19.12(3) *Tariff requirements.* If a company elects to offer flexible rates, the utility shall file for review and approval tariff sheets specifying the general conditions for offering discounted rates. The tariff sheets shall include, at a minimum, the following criteria:

a. The cost-benefit analysis must demonstrate that offering the discount will be more beneficial than not offering the discount.

b. The ceiling for all discounted rates shall be the approved rate on file for the customer's rate class.

c. The floor for the discount sales rates shall be equal to the cost of gas. Therefore, the maximum discount allowed under the sales or transportation tariffs is equal to the nongas costs of serving the customer.

d. No discount shall be offered for a period longer than five years, unless the board determines upon good cause shown that a longer period is warranted.

e. Discounts should not be offered if they will encourage deterioration in the load characteristics of the customer receiving the discount.

f. Customer charges may be discounted.

19.12(4) *Reporting requirements.* Each natural gas utility electing to offer flexible rates shall file annual reports with the board within 30 days of the end of each 12 months. Reports shall include the following information:

a. Section 1 of the report concerns discounts initiated in the last 12 months. For all discounts initiated in the last 12 months, the report shall include:

(1) The identity of the new customers (by account number, if necessary);

(2) The value of the discount offered;

(3) The cost-benefit analysis results;

(4) The cost of alternate fuels available to the customer, if relevant;

(5) The volume of gas sold to or transported for the customer in the preceding 12 months; and

(6) A copy of all new or revised flexible rate contracts executed between the utility and its customers.

b. Section 2 of the report relates to overall program evaluation. For all discounts currently being offered, the report shall include:

(1) The identity of each customer (by account number, if necessary);

(2) The total volume of gas sold or transported in the last 12 months to each customer at discounted rates, by month;

(3) The volume of gas sold or transported to each customer in the same 12 months of the preceding year, by month;

(4) The dollar value of the discount in the last 12 months to each customer, by month;

(5) The dollar value of volumes sold or transported to each customer for each of the previous 12 months; and

(6) If customer charges are discounted, the dollar value of the discount shall be separately reported.

c. Section 3 of the report concerns discounts denied or discounts terminated. For all customers specifically evaluated and denied or having a discount terminated in the last 12 months, the report shall include:

(1) Customer identification (by account number, if necessary);

(2) The volume of gas sold or transported in the last 12 months to each customer, by month;

(3) The volume of gas sold or transported to each customer in the same 12 months of the preceding year, by month; and

(4) The dollar value of volumes sold or transported to each customer for each of the past 12 months.

d. No report is required if the utility had no customers receiving a discount during the relevant period and had no customers which were evaluated for the discount and rejected during the relevant period.

19.12(5) *Rate case treatment.* In a rate case, 50 percent of any identifiable increase in net revenues will be used to reduce rates for all customers; the remaining 50 percent of the identifiable increase in net revenues may be kept by the utility. If there is a decrease in revenues due to the discount, the utility's test year revenues will be adjusted to remove the effects of the discount by assuming that all sales or transportation services or customer charges were provided at full tariffed rate for the customer class. Determining the actual amount will be a factual determination to be made in the rate case.

199—19.13(476) Transportation service.

19.13(1) *Purpose.* This subrule requires gas distribution utility companies to transport natural gas owned by an end-user on a nondiscriminatory basis, subject to the capacity limitations of the specific system. System capacity is defined as the maximum flow of gas the relevant portion of the system is capable of handling. Capacity availability shall be determined using the total current firm gas flow, including both system and transportation gas.

19.13(2) *End-user rights.* The end-user purchasing transportation services from the utility shall have the following rights and be subject to the following conditions:

a. The end-user shall have the right to receive, pursuant to agreement, 100 percent of the gas delivered by it or on its behalf to the transporting utility (adjusted for a reasonable volume of lost, unaccounted-for, and company-used gas).

b. The volumes which the end-user is entitled to receive shall be subject to curtailment or interruption due to limitations in the system capacity of the transporting utility. Curtailment of the transportation volumes will take place according to the priority class, subdivision, or category which the end-user would have been assigned if it were purchasing gas from the transporting utility.

c. During periods of curtailment or interruption, the party is entitled to a credit equal to the difference between the volumes delivered to the utility and those received by the end-user, adjusted for lost, unaccounted-for, and company-used gas. The credit shall be available at any time, within the conditions of the agreement.

d. The end-user shall be responsible for all costs associated with any additional plant required for providing transportation services to the end-user.

19.13(3) *Transportation service charges.* Transportation service shall be offered to at least the following classes:

a. Interruptible service with system supply reserve.

b. Interruptible service without system supply reserve.

c. Firm service with system supply reserve.

d. Firm service without system supply reserve.

19.13(4) *Transportation service charges and rates.* All rates and charges for transportation shall be based on the cost of providing the service.

a. "System supply reserve" service shall entitle the end-user to return to the system service to the extent of the capacity purchased. The charge shall be at least equal to the administrative costs of

monitoring the service, plus any other costs (including but not limited to gas demand costs which are directly assignable to the end-user).

b. End-users without system supply reserve service may only return to system service by paying an additional charge and are subject to the availability of adequate system capacity. An end-user wishing to receive transportation service without system supply reserve must pay the utility for the discounted value of any contract between the utility and the end-user remaining in effect at the time of beginning transportation service. The discounted values shall include all directly assignable and identifiable costs (including but not limited to gas costs).

c. The utility may require a reconnection charge when an end-user receiving transportation service without system supply reserve service requests to return to the system supply. The end-user shall return to the system and receive service under the appropriate classification as determined by the utility.

d. The end-user electing to receive transportation service shall pay reasonable rates for any use of the facilities, equipment, or services of the transporting utility.

e. Small volume transportation service. Rescinded IAB 4/28/04, effective 6/2/04.

f. Optional plan filing. Rescinded IAB 4/28/04, effective 6/2/04.

19.13(5) *Reporting requirements.* A natural gas utility shall file with the board two copies of each transportation contract entered into within 30 days of the date of execution. The utility may delete any information identifying the end-user and replace it with an identification number. The utility shall promptly supply the deleted information if requested by the board staff. The deleted information may be filed with a request for confidentiality, pursuant to 199 Iowa Administrative Code rule 1.9(22).

19.13(6) *Written notice of risks.* The utility must notify its large volume users as defined in 19.14(1) contracting for transportation service in writing that unless the customer buys system supply reserve service from the utility, the utility is not obligated to supply gas to the customer. The notice must also advise the large volume user of the nature of any identifiable penalties, any administrative or reconnection costs associated with purchasing available firm or interruptible gas, and how any available gas would be priced by the utility. The notice may be provided through a contract provision or separate written instrument. The large volume user must acknowledge in writing that it has been made aware of the risks and accepts the risks.

199—19.14(476) Certification of competitive natural gas providers and aggregators.

19.14(1) *Definitions.* The following words and terms, when used in these rules, shall have the meanings indicated below:

"Competitive natural gas provider" or *"CNGP"* means a person who takes title to natural gas and sells it for consumption by a retail end user in the state of Iowa, and it also means an aggregator as defined in Iowa Code section 476.86. CNGP includes an affiliate of an Iowa public utility. CNGP excludes the following:

1. A public utility which is subject to rate regulation under Iowa Code chapter 476.

2. A municipally owned utility which provides natural gas service within its incorporated area or within the municipal natural gas competitive service area, as defined in Iowa Code section 437A.3(21)*"a"*(1), in which the municipally owned utility is located.

"Competitive natural gas services" means natural gas sold at retail in this state excluding the sale of natural gas by a rate-regulated public utility or a municipally owned utility as provided in the definition of CNGP in 19.14(1).

"Large volume user" means any end user whose usage exceeds 25,000 therms in any month or 100,000 therms in any consecutive 12-month period.

"Small volume user" means any end user whose usage does not exceed 25,000 therms in any month and does not exceed 100,000 therms in any consecutive 12-month period.

19.14(2) *General requirement to obtain certificate.* A CNGP shall not provide competitive natural gas services to an Iowa retail end user without a certificate approved by the board pursuant to Iowa Code section 476.87. An exception to this requirement is a CNGP that has provided service to retail customers before April 25, 2001. A CNGP subject to this exception shall file for a certificate under the provisions of this rule on or before June 1, 2001, to continue providing service pending the approval of the certificate.

19.14(3) *Filing requirements and application process.* Applications shall be made in the format and contain all of the information required in 199—subrule 2.2(18). Applications must be filed with the executive secretary at Iowa Utilities Board, 350 Maple Street, Des Moines, Iowa 50319-0069. An original and ten copies must be filed. An application fee of $125 must be included with the application to cover the administrative costs of accepting and processing a filing. In addition, each applicant will be billed an hourly rate for actual time spent by the board reviewing the application. Iowa Code section 476.87(3) requires the board to allocate the costs and expenses reasonably attributable to certification and dispute resolution to applicants and participants to the proceeding.

An applicant shall notify the board during the pendency of the certification request of any material change in the representations and commitments required by this subrule within 14 days of such change. Any new legal actions or formal complaints as identified in 199 IAC 2.2(18), numbered paragraph "4," are considered material changes in the request. Once certified, CNGPs shall notify the board of any material change in the representations and commitments required for certification within 14 days of such change.

19.14(4) *Deficiencies and board determination.* The board shall act on a certification application within 90 days unless it determines an additional 60 days is necessary. Applications will be considered complete and the 90-day period will commence when all required items are submitted. Applicants will be notified of deficiencies and given 30 days to complete applications. Applicants will be notified when their application is complete and the 90-day period commences.

19.14(5) *Conditions of certification.* CNGPs shall comply with the conditions set out in this subrule. Failure to comply with the conditions of certification may result in revocation of the certificate.

a. Unauthorized charges. A CNGP shall not charge or attempt to collect any charges from end users for any competitive natural gas services or equipment used in providing competitive natural gas services not contracted for or otherwise agreed to by the end user.

b. Notification of emergencies. Upon receipt of information from an end user of the existence of an emergency situation with respect to delivery service, a CNGP shall immediately contact the appropriate public utility whose facilities may be involved. The CNGP shall also provide the end user with the emergency telephone number of the public utility.

c. Reports to the board. Each CNGP shall file a report with the board on April 1 of each year for the 12-month period ending December 31 of the previous year. This information may be filed with a request for confidentiality, pursuant to 199—subrule 1.9(6). For each utility distribution system, the report shall contain the following information for its Iowa operations:

(1) The average number of small volume end users served per month.

(2) The average number of large volume end users served per month.

(3) The total volume of sales to small volume end users, by month.

(4) The total volume of sales to large volume end users, by month.

(5) The revenue collected from small volume end users for competitive natural gas services, excluding any revenue collected from end users on behalf of utilities.

(6) The revenue collected from large volume end users for competitive natural gas services, excluding any revenue collected from end users on behalf of utilities.

(7) The date the applicant began providing service in Iowa.

d. Rescinded IAB 4/28/04, effective 6/2/04.

19.14(6) *Additional conditions applicable to CNGPs providing service to small volume end users.* All CNGPs when providing service to small volume natural gas end users shall be subject to the following conditions in addition to those listed under subrule 19.14(5):

a. Customer deposits. Compliance with the following provisions shall apply to customers whose usage does not exceed 2500 therms in any month or 10,000 therms in any consecutive 12-month period.

Customer deposits – subrule 19.4(2)

Interest on customer deposits – subrule 19.4(3)

Customer deposit records – subrule 19.4(4)

Customer's receipt for a deposit – subrule 19.4(5)

Deposit refund – subrule 19.4(6)

Unclaimed deposits – subrule 19.4(7)

b. Bills to end users. A CNGP shall include on bills to end users all the information listed in this paragraph. The bill may be sent to the customer electronically at the customer's option.

(1) The period of time for which the billing is applicable.

(2) The amount owed for current service, including an itemization of all charges.

(3) Any past-due amount owed.

(4) The last date for timely payment.

(5) The amount of penalty for any late payment.

(6) The location for or method of remitting payment.

(7) A toll-free telephone number for the end user to call for information and to make complaints regarding the CNGP.

(8) A toll-free telephone number for the end user to contact the CNGP in the event of an emergency.

(9) A toll-free telephone number for the end user to notify the public utility of an emergency regarding delivery service.

(10) The tariffed transportation charges and supplier refunds, where a combined bill is provided to the customer.

c. Disclosure. Each prospective end user must receive in writing, prior to initiation of service, all terms and conditions of service and all rights and responsibilities of the end user associated with the offered service. The information required by this paragraph may be provided electronically, at the customer's option.

d. Notice of service termination. Notice must be provided to the end user and the public utility at least 12 calendar days prior to service termination. If the notice of service termination is rescinded, the CNGP must notify the public utility. CNGPs are prohibited from physically disconnecting the end user or threatening physical disconnection for any reason.

e. Transfer of accounts. CNGPs are prohibited from transferring the account of any end user to another supplier except with the consent of the end user. This provision does not preclude a CNGP from transferring all or a portion of its accounts pursuant to a sale or transfer of all or a substantial portion of a CNGP's business in Iowa, provided that the transfer satisfies all of the following conditions:

(1) The transferee will serve the affected end users through a certified CNGP;

(2) The transferee will honor the transferor's contracts with the affected end users;

(3) The transferor provides written notice of the transfer to each affected end user prior to the transfer;

(4) Any affected end user is given 30 days to change supplier without penalty; and

(5) The transferor provides notice to the public utility of the effective date of the transfer.

f. Bond requirement. The board may require the applicant to file a bond or other demonstration of its financial capability to satisfy claims and expenses that can reasonably be anticipated to occur as part of operations under its certificate, including the failure to honor contractual commitments. The adequacy of the bond or demonstration shall be determined by the board and reviewed by the board from time to time. In determining the adequacy of the bond or demonstration, the board shall consider the extent of the services to be offered, the size of the provider, and the size of the load to be served, with the objective of ensuring that the board's financial requirements do not create unreasonable barriers to market entry.

g. Replacement cost for supply failure. Each individual rate-regulated public utility shall file for the board's review tariffs establishing replacement cost for supply failure. Replacement cost revenue will be credited to the rate-regulated public utility's system purchased gas adjustment.

199—19.15(476) Customer contribution fund.

19.15(1) *Applicability and purpose.* This rule applies to each gas public utility, as defined in Iowa Code sections 476.1 and 476.1B. Each utility shall maintain a program plan to assist the utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home energy assistance program for the payment of winter heating bills.

19.15(2) *Program plan.* Each utility shall have on file with the board a detailed description of its program plan. At a minimum, the plan shall include the following information:

a. A list of the members of the governing board, council, or committee established to determine the appropriate distribution of the funds collected. The list shall include the organization each member represents;

b. A sample of the customer notification with a description of the method and frequency of its distribution;

c. A sample of the authorization form provided to customers; and

d. The date of implementation.

Program plans for new customer contribution funds shall be rejected if not in compliance with this rule.

19.15(3) *Notification.* Each utility shall notify all customers of the fund at least twice a year. The method of notice which will ensure the most comprehensive notification to the utility's customers shall be employed. Upon commencement of service and at least once a year, the notice shall be mailed or personally delivered to all customers. The other required notice may be published in a local newspaper(s) of general circulation within the utility's service territory. A utility serving fewer than 6,000 customers may publish their semiannual notices locally in a free newspaper, utility newsletter or shopper's guide instead of a newspaper. At a minimum the notice shall include:

a. A description of the availability and the purpose of the fund;

b. A customer authorization form. This form shall include a monthly billing option and any other methods of contribution.

19.15(4) *Methods of contribution.* The utility shall provide for contributions as monthly pledges, as well as one-time or periodic contributions. Each utility may allow persons or organizations to contribute matching funds.

19.15(5) *Annual report.* On or before September 30 of each year, each utility shall file with the board a report of all the customer contribution fund activity for the previous fiscal year beginning July 1 and ending June 30. The report shall be in a form provided by the board and shall contain an accounting of the total revenues collected and all distributions of the fund. The utility shall report all utility expenses directly related to the customer contribution fund.

19.15(6) *Binding effect.* A pledge by a customer or other party shall not be construed to be a binding contract between the utility and the pledgor. The pledge amount shall not be subject to delayed payment charges by the utility.

199—19.16(476) Reserve margin.

19.16(1) *Applicability.* All rate-regulated gas utility companies may maintain a reserve of contract services in excess of their maximum daily system demand requirement and recover the cost of the reserve from their customers through the purchased gas adjustment.

19.16(2) *Definitions.*

a. Contract services. The amount of firm gas delivery capacity or delivery services contracted for use by a utility to satisfy its maximum daily system demand requirement, including the planned delivery capacity of the utility-owned liquefied natural gas facilities, but excluding the delivery capacity of propane storage facilities, shall be considered as contract services.

b. Maximum daily system demand requirements. The maximum daily gas demand requirement that the utility forecasts to occur on behalf of its system firm sales customers under peak (design day) weather conditions.

c. Design day. The maximum heating season forecast level of all firm sales customers' gas requirements during a 24-hour period beginning at 9 a.m. The design day forecast shall be the combined estimated gas requirements of all firm sales customers calculated by totaling the gas requirements of each customer classification or grouping. The estimated gas requirements for each customer classification or grouping shall be determined based upon an evaluation of historic usage levels of customers in each customer classification or grouping, adjusted for reasonably anticipated colder-than-normal weather conditions and any other clearly identifiable factors that may contribute to the demand for gas by firm

customers. The design day calculation shall be submitted for approval by the board with the annual PGA filing required by subrule 19.10(2).

19.16(3) *Maximum daily system demand requirements of less than 25,000 Dth per day.* A reserve margin of 9 percent or less in excess of the maximum daily system demand requirements will be presumed reasonable.

19.16(4) *Maximum daily system demand requirements of more than 25,000 Dth per day.* A reserve margin of 5 percent or less in excess of the maximum daily system demand requirements will be presumed reasonable.

19.16(5) *Rebuttable presumption.* All contract services in excess of an amount needed to meet the maximum daily system demand requirements plus the reserve are presumed to be unjust and unreasonable unless a factual showing to the contrary is made during the periodic review of gas proceeding or in a proceeding specifically addressing the issue with an opportunity for an evidentiary hearing. All contract services less than an amount of the maximum daily system demand requirements plus the reserve are presumed to be just and reasonable unless a factual showing to the contrary can be made during the periodic review of gas proceeding or in a proceeding specifically addressing the issue with an opportunity for an evidentiary hearing.

19.16(6) *Allocation of cost of the reserve.* Fifty percent of the reserve cost shall be collected as a demand charge allocation to noncontractual firm customers. The remaining 50 percent shall be collected as a throughput charge on customers excluding transportation customers who have elected no system supply reserve.

199—19.17(476) Incident notification and reports.

19.17(1) *Notification.* A utility shall notify the board immediately, or as soon as practical, of any incident involving the release of gas, failure of equipment, or interruption of facility operations, which results in any of the following:

a. A death or personal injury necessitating in-patient hospitalization.

b. Estimated property damage of $15,000 or more to the property of the utility and to others, including the cost of gas lost.

c. Emergency shutdown of a liquefied natural gas (LNG) facility.

d. An interruption of service to 50 or more customers.

e. Any other incident considered significant by the utility.

19.17(2) *Information required.* The utility shall notify the board by telephone, as soon as practical, of any reportable incident by calling the board duty officer at 515-745-2332. The caller shall leave a call-back number for a person who can provide the following information:

a. The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the incident.

b. The location of the incident.

c. The time of the incident.

d. The number of deaths or personal injuries and the extent of those injuries, if any.

e. An initial estimate of damages.

f. The number of services interrupted.

g. A summary of the significant information available to the utility regarding the probable cause of the incident and extent of damages.

h. Any oral or written report required by the U.S. Department of Transportation, and the name of the person who made the oral report or prepared the written report.

19.17(3) *Written incident reports.* Within 30 days of the date of the incident, the utility shall file a written report with the board. The report shall include the information required for telephone notice in subrule 19.17(2), the probable cause as determined by the utility, the number and cause of any deaths or personal injuries requiring in-patient hospitalization, and a detailed description of property damage and the amount of monetary damages. If significant additional information becomes available at a later date, a supplemental report shall be filed. Copies of any written reports concerning an incident or safety-related

condition filed with or submitted to the U.S. Department of Transportation or the National Transportation Safety Board shall also be provided to the board.

These rules are intended to implement 42 U.S.C.A. 8372, 10 CFR, 516.30, and Iowa Code sections 476.1, 476.2, 476.6, 476.8, 476.20, 476.54, 476.66, 476.86, 476.87 and 546.7.

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1 Effective date of 19.3(10)*"a," "b,"*(1), (2), (2)"1," (3) and (4) delayed 70 days by administrative rules review committee.

2 Effective date of 19.4(11), third unnumbered paragraph, delayed 70 days by administrative rules review committee.

3 See IAB, Utilities Division

4 Published in Notice portion of IAB 9/10/86; See IAB 10/22/86

5 Effective date of 19.4(3) delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 20
SERVICE SUPPLIED BY ELECTRIC UTILITIES
[Prior to 10/8/86, Commerce Commission[250]]

199—20.1(476) General information.

20.1(1) *Authorization of rules.* Iowa Code chapter 476 provides that the Iowa utilities board shall establish all needful, just and reasonable rules, not inconsistent with law, to govern the exercise of its powers and duties, the practice and procedure before it, and to govern the form, content and filing of reports, documents and other papers necessary to carry out the provisions of this law.

Iowa Code chapter 478 provides that the Iowa utilities board shall have power to make and enforce rules relating to the location, construction, operation and maintenance of certain electrical transmission lines.

The application of the rules in this chapter to municipally owned utilities furnishing electricity is limited by Iowa Code section 476.1B, and the application of the rules in this chapter to electric utilities with fewer than 10,000 customers and to electric cooperative associations is limited by the provisions of Iowa Code section 476.1A.

20.1(2) *Application of rules.* The rules shall apply to any electric utility operating within the state of Iowa subject to Iowa Code chapter 476, and to the construction, operation and maintenance of electric transmission lines to the extent provided in Iowa Code chapter 478, and shall supersede all tariffs on file with the board which are in conflict with these rules.

These rules are intended to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities.

A request to waive the application of any rule on a permanent or temporary basis may be made in accordance with 199—1.3(17A,474,476,78GA,HF2206).

The adoption of these rules shall in no way preclude the board from altering or amending them pursuant to statute or from making such modifications with respect to their application as may be found necessary to meet exceptional conditions.

These rules shall in no way relieve any utility from any of its duties under the laws of this state.

20.1(3) *Definitions.* The following words and terms when used in these rules, shall have the meaning indicated below:

"Acid Rain Program" means the sulfur dioxide and nitrogen oxides air pollution control program established pursuant to Title IV of the Act under 40 CFR Parts 72-78.

"Act" means the Clean Air Act, 42 U.S.C. Section 7401, et seq., as amended by Pub. L. 101-549, November 15, 1990.

"Affected unit" means a unit or source that is subject to any emission reduction requirement or limitation under the Acid Rain Program, the Clean Air Interstate Rule (CAIR) or the Clean Air Mercury Rule (CAMR), or a unit or source that opts in under 40 CFR Part 74.

"Allowance" means an authorization, allocated by the United States Environmental Protection Agency (EPA) under the Acid Rain Program, to emit sulfur dioxide (SO_2), any SO_2 and nitrogen oxide (NO_X) emissions subject to the Clean Air Interstate Rule (CAIR), or mercury (Hg) emissions subject to the Clean Air Mercury Rule (CAMR), during or after a specified calendar year.

"Allowance forward contract" is an agreement between a buyer and seller to transfer an allowance on a specified future date at a specified price.

"Allowance futures contract" is an agreement between a futures exchange clearinghouse and a buyer or seller to buy or sell an allowance on a specified future date at a specified price.

"Allowance option contract" is an agreement between a buyer and seller whereby the buyer has the option to transfer an allowance(s) at a specified date at a specified price. The seller of a call or put option will receive a premium for taking on the associated risk.

"Board" means the utilities board.

"Clean Air Interstate Rule" or *"CAIR"* means the requirements EPA published in the Federal Register (70 Fed. Reg. 25161) on May 12, 2005.

"Clean Air Mercury Rule" or *"CAMR"* means the requirements EPA published in the Federal Register (70 Fed. Reg. 28605) on May 18, 2005.

"Complaint" as used in these rules is a statement or question by anyone, whether a utility customer or not, alleging a wrong, grievance, injury, dissatisfaction, illegal action or procedure, dangerous condition or action, or utility obligation.

"Compliance plan" means the document submitted for an affected source to the EPA which specifies the methods by which each affected unit at the source will meet the applicable emissions limitation and emissions reduction requirements.

"Customer" means any person, firm, association, or corporation, any agency of the federal, state or local government, or legal entity responsible by law for payment for the electric service or heat from the electric utility.

"Delinquent" or *" delinquency"* means an account for which a service bill or service payment agreement has not been paid in full on or before the last day for timely payment.

"Distribution line" means any single or multiphase electric power line operating at nominal voltage in either of the following ranges: 2,000 to 26,000 volts between ungrounded conductors or 1,155 to 15,000 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

"Economy energy" is energy bought or sold in a transaction wherein the supplier's incremental cost is less than the buyer's decremental cost, and the differential in cost is shared in an equitable manner by the supplier and buyer.

"Electric plant" includes all real estate, fixtures and property owned, controlled, operated or managed in connection with or to facilitate production, generation, transmission, or distribution, in providing electric service or heat by an electric utility.

"Electric service" is furnishing to the public for compensation any electricity, heat, light, power, or energy.

"Emission for emission trade" is an exchange of one type of emission for another type of emission. For example, the exchange of SO_2 emission allowances for NO_X emission allowances.

"Energy" means electric energy measured in kilowatt hours.

"Firm power" is power and associated energy intended to be available at all times during the period covered by the commitment.

"Gains and losses from allowance sales" are calculated as the difference between the sale price of allowances sold during the month and the weighted average unit cost of inventoried allowances.

"Meter" means, unless otherwise qualified, a device that measures and registers the integral of an electrical quantity with respect to time.

"Meter shop" is a shop where meters are inspected, repaired and tested, and may be at a fixed location or may be mobile.

"Operating reserve" is a reserve generating capacity required to ensure reliability of generation resources.

"Operational control energy" is energy supplied by a selling utility to a buying utility for the improvement of electric system operation.

"Outage energy" is energy purchased during emergency or scheduled maintenance outages of generation or transmission facilities, or both.

"Participation power" means power and associated energy or energy which is purchased or sold from a specific unit or units on the basis that its availability is subject to prorate or other specified reduction if the units are not operated at full capacity.

"Peaking power" is power and associated energy intended to be available at all times during the commitment and which is anticipated to have low load factor use.

"Power" means electric power measured in kilowatts.

"Price hedging" means using futures contracts or options to guard against unfavorable price changes.

"Rate-regulated utility" means any utility, as defined in 20.1(3),which is subject to board rate regulation under Iowa Code chapter 476.

"Secondary line" means any single or multiphase electric power line operating at nominal voltage less than either 2,000 volts between ungrounded conductors or 1,155 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

"Service limitation" means the establishment of a limit on the amount of power that may be consumed by a residential customer through the installation of a service limiter on the customer's meter.

"Service limiter" means a circuit breaker device that limits a residential customer's power consumption to 15 amps at 120 volts (or some higher level of usage approved by the board) and that either resets itself automatically or can be reset by the customer.

"Speculation" means using futures contracts or options to profit from expectations of future price changes.

"Tariff" means the entire body of rates, tolls, rentals, charges, classifications, rules, procedures, policies, etc., adopted and filed with the board by an electric utility in fulfilling its role of furnishing service.

"Timely payment" is a payment on a customer's account made on or before the date shown on a current bill for service, or on a form which records an agreement between the customer and a utility for a series of partial payments to settle a delinquent account, as the date which determines application of a late payment charge to the current bill or future collection efforts.

"Transmission line" means any single or multiphase electric power line operating at nominal voltages at or in excess of either 69,000 volts between ungrounded conductors or 40,000 volts between grounded and ungrounded conductors, regardless of the functional service provided by the line.

"Utility" means any person, partnership, business association or corporation, domestic or foreign, owning or operating any facilities for providing electric service or heat to the public for compensation.

"Vintage trade" is an exchange of one vintage of allowances for another vintage of allowances with the difference in value between vintages being cash or additional allowances.

"Weighted average unit cost of inventoried allowances" equals the dollars in inventory at the end of the month divided by the total allowances available for use at the end of the month.

"Wheeling service" is the service provided by a utility in consenting to the use of its transmission facilities by another party for the purpose of scheduling delivery of power or energy, or both.

20.1(4) *Abbreviations.* The following abbreviations may be used where appropriate:

ANSI—American National Standards Institute, 1430 Broadway, New York, New York 10018.

DOE—Department of Energy, Washington, D.C. 20426.

EPA—United States Environmental Protection Agency.

FCC—Federal Communications Commission, 1919 M Street, Washington, D.C. 20554.

FERC—Federal Energy Regulatory Commission, Washington, D.C. 20426.

NARUC—National Association of Regulatory Utility Commissioners, P.O. Box 684, Washington, D.C. 20044.

NBS—National Bureau of Standards, Washington, D.C. 20234.

NFPA—National Fire Protection Association, 470 Atlantic Ave., Boston, Massachusetts 02210.

199—20.2(476) Records, reports, and tariffs.

20.2(1) *Location and retention of records.* Unless otherwise specified by this chapter, all records required by these rules shall be kept and preserved in accordance with the applicable provisions of 199—Chapter 18.

20.2(2) *Tariffs to be filed with the board.* The schedules of rates and rules of rate-regulated electric utilities shall be filed with the board and shall be classified, designated, arranged and submitted so as to conform to the requirements of this chapter. Provisions of the schedules shall be definite and so stated as to minimize ambiguity or the possibility of misinterpretation. The form, identification and content of tariffs shall be in accordance with these rules.

Utilities which are not subject to the rate regulation provided for by Iowa Code chapter 476 shall not be required to file schedules of rates, rules, or contracts primarily concerned with a rate schedule with the board and shall not be subject to the provisions related to rate regulations, but nothing contained in these rules shall be deemed to relieve any utility of the requirement of furnishing any of these same schedules

or contracts which are needed by the board in the performance of the board's duties upon request to do so by the board.

20.2(3) *Form and identification.* All tariffs shall conform to the following rules:

a. The tariff shall be printed, typewritten or otherwise reproduced on 8½- × 11- inch sheets of durable white paper so as to result in a clear and permanent record. The sheets of the tariff should be ruled or spaced to set off a border on the left side suitable for binding. In the case of utilities subject to regulation by any federal agency the format of sheets of tariff as filed with the board may be the same format as is required by the federal agency provided that the rules of the board as to title page; identity of superseding, replacing or revision sheets; identity of amending sheets: identity of the filing utility, issuing official, date of issue, effective date; and the words "Tariff with board" shall apply in the modification of the federal agency format for the purposes of filing with this board.

b. The title page of every tariff and supplement shall show:

(1) The first page shall be the title page which shall show:

(Name of Public Utility)
Electric Tariff
Filed with
Iowa Utilities Board

(Date)

(This requirement does not apply to tariffs or amendments filed with the board prior to July 1, 1981.)

(2) When a tariff is to be superseded or replaced in its entirety, the replacing tariff shall show on the upper right corner of its title page that it supersedes a tariff on file and the number being superseded or replaced, for example:

TARIFF NO. _____
SUPERSEDES TARIFF NO. _____

(This requirement does not apply to tariffs or amendments filed with the board prior to July 1, 1981.)

(3) When a new part of a tariff eliminates an existing part of a tariff it shall so state and clearly indicate the part eliminated.

(4) Any tariff modifications as defined above shall be marked in the right-hand margin of the replacing tariff sheet with symbols as here described to indicate the place, nature and extent of the change in text.

—Symbols—

(C)—Changed regulation
(D)—Discontinued rate or regulation
(I)—Increase in rate or new treatment resulting in increased rate
(N)—New rate, treatment or regulation
(R)—Reduction in rate or new treatment resulting in reduced rate
(T)—Change in text only

c. All sheets except the title page shall have, in addition to the above-stated requirements, the following information:

(1) Name of utility under which shall be set forth the words "Filed with board." If the utility is not a corporation, and a trade name is used, the name of the individual or partners must precede the trade name.

(2) Issuing official and issue date.

(3) Effective date (to be left blank by rate-regulated utilities).

d. All sheets except the title page shall have the following form:

(Company Name)	(Part identification)
Electric Tariff	(This sheet identification)
Filed with board	(Canceled sheet identification, if any)

	(Content or tariff)
Issued: (Date)	Effective:
Issued by: (Name, title)	(Proposed Effective Date:)

The issued date is the date the tariff or the amended sheet content was adopted by the utility.

The effective date will be left blank by rate-regulated utilities and shall be determined by the board. The utility may propose an effective date.

20.2(4) *Content of tariffs.*

a. A table of contents containing a list of rate schedules and other sections in the order in which they appear showing the sheet numbers of the first page of each rate schedule or other section. In the event the utility filing the tariff elects to segregate a section such as general rules from the section containing the rate schedules or other sections, it may at its option prepare a separate table of contents for each such segregated section.

b. A preliminary statement containing a brief general explanation of the utility's operations.

c. All rates for service with indication for each rate of the type and voltage of service and the class of customers to which each rate applies. There shall also be shown any limitations on loads and type of equipment which may be connected, the net prices per unit of service and the number of units per billing period to which the net prices apply, the period of billing, the minimum bill, any effect of transformer capacity upon minimum bill or upon the number of kWh in any step of the rate, method of measuring demands, method of calculating or estimating loads in cases where transformer capacity has a bearing upon minimum bill or size of rate steps, level payment plan, and any special terms or conditions applicable. The period during which the net amount may be paid before the account becomes delinquent shall be specified. In any case where net and gross amounts are billed, the difference between net and gross is a late payment charge and shall be so specified.

d. The voltage and type of service, (direct current or single or polyphase alternating current) supplied in each municipality, but without reference required to any particular part thereof.

e. Forms of standard contracts required of customers for the various types of service available.

f. If service to other utilities or municipalities is furnished at a standard filed rate, either a copy of each signed contract or a copy of the standard uniform contract form together with a summary of the provisions of each signed contract. The summary shall show the principal provisions of the contract and shall include the name and address of the customer, the points where energy is delivered, rate, term, minimum, load conditions, voltage of delivery and any special provisions such as rentals. Standard contracts for such sales as that of energy for resale, street lighting, municipal athletic field lighting, and for water utilities may be filed in summary form as above outlined.

g. Copies of special contracts for the purchase, sale, or interchange of electrical energy. All tariffs must provide that, notwithstanding any other provision of this tariff or contract with reference thereto, all rates and charges contained in this tariff or contract with reference thereto may be modified at any time by a subsequent filing made pursuant to the provisions of Iowa Code chapter 476.

h. A list of all communities in which service is furnished.

i. The list of service areas and the rates shall be filed in a form to facilitate ready determination of the rates available in each municipality and in unincorporated communities that have service. If the utility has various rural rates, the areas where the same are available shall be indicated.

j. Definitions of classes of customers.

k. Extension rules for extending service to new customers indicating what portion of the extension or cost thereof will be furnished by the utility; and if the rule is based on cost, the items of cost included.

l. Type of construction which the utility requires the customer to provide if in excess of the Iowa electric safety code or the requirements of the municipality having jurisdiction, whichever may be the most stringent in any particular.

m. Specification of such portion of service as the utility furnishes, owns, and maintains, such as service drop, service entrance cable or conductors, conduits, service entrance equipment, meter and socket. Indication of the portions of interior wiring such as range or water heater connection, furnished in

whole or in part by the utility, and statement indicating final ownership and responsibility for maintaining equipment furnished by utility.

n. Statement of the type of special construction commonly requested by customers which the utility allows to be connected, and terms upon which such construction will be permitted, with due provision for the avoidance of unjust discrimination as between customers who request special construction and those who do not. This applies, for example, to a case where a customer desires underground service in overhead territory.

o. Rules with which prospective customers must comply as a condition of receiving service, and the terms of contracts required.

p. Rules governing the establishment and maintenance of credit by customers for payment of service bills.

q. Rules governing the procedure followed in disconnecting and reconnecting service.

r. Notice required from a customer for having service discontinued.

s. Rules covering temporary, emergency, auxiliary and stand-by service.

t. Rules covering the type of equipment which may or may not be connected, including rules such as those requiring demand-limiting devices or power-factor corrective equipment.

u. General statement of the method used in making adjustments for wastage of electricity when accidental grounds exist without the knowledge of the customer.

v. Statements of utility rules on meter reading, bill issuance, customer payment, notice of delinquency, and service discontinuance for nonpayment of bill.

w. Rules for extending service in accordance with 20.3(13).

x. If a sliding scale or automatic adjustment is applicable to regulated rates and charges of billed customers, the manner and method of such adjustment calculation shall be covered through a detailed explanation.

y. Rules on how a customer or prospective customer should file a complaint with the utility, and how the complaint will be processed.

z. Rules on how a customer, disconnected customer or potential customer for residential service may negotiate for a payment agreement on amount due, determination of even payment amounts, and time allowed for payments.

20.2(5) *Annual, periodic and other reports to be filed with the board.*

a. System map verification. The utility shall file annually a verification that it has a currently correct set of utility system maps in accordance with general requirement 20.3(11) and a statement as to the location of the utility's offices where such maps are accessible and available for examination by the board or its agents. The verification and map location information shall also be reported to the board upon other occasions when significant changes occur in either the maps or location of the maps.

b. Accident reports. Rescinded IAB 12/11/91, effective 1/15/92. See 199—25.5(476,478).

c. Rescinded IAB 11/13/02, effective 12/18/02.

d. Electric service record. Each utility shall compile a monthly record of electric service showing the production, acquisition and disposition of electric energy, the number of customer terminal voltage investigations made, the number of customer meters tested and such other information as may be required by the board. The monthly "Electric Service" record shall be compiled not later than 30 days after the end of the month covered and such record shall, upon and after compilation, be kept available for inspection by the board or its staff at the utility's principal office within the state of Iowa. A summary of the 12 monthly "Electric Service" records for each calendar year shall be attached to and submitted with the utility's annual report to the board.

e. The utility shall keep the board informed currently by written notice as to the location at which the utility keeps the various classes of records required by these rules.

f. A copy of the utility's current rules, if any, published or furnished by the utility for the use of engineers, architects, electrical contractors, etc., covering meter and service installations shall be filed with the board.

g. A copy of each type of customer bill form in current use shall be filed with the board.

h. A copy of the adjustment calculation shall be provided the board prior to each billing cycle on the forms adopted by the board.

i. Rescinded IAB 1/9/91, effective 2/13/91.

j. Residential customer statistics. Each rate-regulated electric utility shall file with the board on or before the fifteenth day of each month one copy of the following residential customer statistics for the preceding month:

(1) Number of accounts;
(2) Number of accounts certified as eligible for energy assistance since the preceding October 1;
(3) Number of accounts past due;
(4) Number of accounts eligible for energy assistance and past due;
(5) Total revenue owed on accounts past due;
(6) Total revenue owed on accounts eligible for energy assistance and past due;
(7) Number of disconnection notices issued;
(8) Number of disconnection notices issued on accounts eligible for energy assistance;
(9) Number of disconnections for nonpayment;
(10) Number of reconnections;
(11) Number of accounts determined uncollectible; and
(12) Number of accounts eligible for energy assistance and determined uncollectible.

k. List of persons authorized to receive board inquiries. Each utility shall file with the board in the annual report required in 199—subrule 23.1(2) a list of names, titles, addresses, and telephone numbers of persons authorized to receive, act upon, and respond to communications from the board in connection with: (1) general management duties; (2) customer relations (complaints); (3) engineering operations; (4) meter tests and repairs; (5) franchises for electric lines; (6) certificates for electric generating plants. Each utility shall file with the board a telephone contact number where the board can obtain current information 24 hours a day about outages and interruptions of service from a knowledgeable person. The contact information required by this paragraph shall be kept current as changes or corrections are made.

This rule is intended to implement Iowa Code section 476.2.

199—20.3(476) General service requirements.

20.3(1) *Disposition of electricity.* The meter and associated instrument transformers shall be owned by the utility. The wiring between the instrument transformers and the meter shall be owned or controlled by the utility. The utility shall place a visible seal on all meters in customer use, such that the seal must be broken to gain entry.

a. All electricity sold by a utility shall be on the basis of meter measurement except:

(1) Where the consumption of electricity may be readily computed without metering; or
(2) For temporary service installations.

b. The amount of all electricity delivered to multioccupancy premises within a single building, where units are separately rented or owned, shall be measured on the basis of individual meter measurement for each unit, except in the following instances:

(1) Where electricity is used in centralized heating, cooling, water-heating, or ventilation systems;
(2) Where a facility is designated for elderly or handicapped persons;
(3) Where submetering or resale of service was permitted prior to 1966; or
(4) Where individual metering is impractical. "Impractical" means: (1) where conditions or structural barriers exist in the multioccupancy building that would make individual meters unsafe or physically impossible to install; (2) where the cost of providing individual metering exceeds the long-term benefits of individual metering; or (3) where the benefits of individual metering (reduced and controlled energy consumption) are more effectively accomplished through a master meter arrangement.

If a multioccupancy building is master-metered, the end-user occupants may be charged for electricity as an unidentified portion of the rent, condominium fee, or similar payment, or, if some other method of allocating the cost of the electric service is used, the total charge for electric service shall not exceed the total electric bill charged by the utility for the same period.

c. Master metering to multiple buildings is prohibited, except for multiple buildings owned by the same person or entity. Multioccupancy premises within a multiple building complex may be master-metered pursuant to this paragraph only if the requirements of paragraph 20.3(1)*"b"* have been met.

d. For purposes of this subrule, a "master meter" means a single meter used in determining the amount of electricity provided to a multioccupancy building or multiple buildings.

e. This rule shall not be construed to prohibit any utility from requiring more extensive individual metering than otherwise required by this rule if pursuant to tariffs filed with and approved by the board.

f. All electricity consumed by the utility shall be on the basis of meter measurement except where consumption may be readily computed without metering, or where metering is impractical.

20.3(2) *Condition of meter.* Rescinded IAB 11/12/03, effective 12/17/03.

20.3(3) *Meter reading records.* The meter reading records shall show:

a. Customer's name, address, and rate schedule or identification of rate schedule.

b. Identification of the meter or meters either by permanently marked utility number or by manufacturer's name, type number and serial number.

c. Meter readings.

d. If the reading has been estimated.

e. Any applicable multiplier or constant.

20.3(4) *Meter charts.* All charts taken from recording meters shall be marked with the initial and final date and hour of the record, the meter identification, customer's name and location and the chart multiplier.

20.3(5) *Meter register.* If it is necessary to apply a multiplier to the meter readings, the multiplier must be marked on the face of the meter register or stenciled in weather resistant paint upon the front cover of the meter. Customers shall have continuous visual access to meter registers as a means of verifying the accuracy of bills presented to them and for implementing such energy conservation initiatives as they desire, except in the individual locations where the utility has experienced vandalism to windows in the protective enclosures. Where remote meter reading is used, whether outdoor on premises or off premises automated, the customer shall also have readable meter registers at the meter.

Where magnetic tape or other delayed processing means is used the utility may comply by having readable kWh registers only, visually accessible.

In instances in which the utility has determined that readable access, to locations existing July 1, 1981, will create a safety hazard, the utility is exempted from the access provisions above.

In instances when a building owner has determined that unrestricted access to tenant metering installation would create a vandalism or safety hazard the utility is exempted from the access provision above.

Continuing efforts should be made to eliminate or minimize the number of restricted locations. The utility should assist affected customers in obtaining meter register information.

20.3(6) *Meter reading and billing interval.* Readings of all meters used for determining charges and billings to customers shall be scheduled at least monthly and for the beginning and termination of service. Bills to larger customers may, for good cause, be rendered weekly or daily for a period not to exceed one month. Intervals other than monthly shall not be applied to smaller customers, or to larger customers after the initial month provided above, without a waiver from the board. A waiver request must include sufficient information to comply with 199—1.3(17A,474,476,78GA,HF2206). If the board denies a waiver, or if a waiver is not sought with respect to a high demand customer after the initial month, that customer's meter shall be read monthly for the next 12 months. The group of larger customers to which shorter billing intervals may be applied shall be specified in the utility's tariff sheets, but shall not include residential customers.

An effort shall be made to obtain readings of the meters on corresponding days of each meter-reading period. When the meter reading date causes a given billing period to deviate by more than 10 percent (counting only business days) from the normal meter reading period, such bills shall be prorated on a daily basis.

The utility may permit the customer to supply the meter readings by telephone or on a form supplied by the utility. The utility may arrange for customer meter reading forms to be delivered to the utility by United States mail, electronically, or by hand delivery. The utility may arrange for the meter to be read by electronic means. Unless the utility has a plan to test check meter readings, a utility representative shall physically read the meter at least once each 12 months.

In the event that the utility leaves a meter reading form with the customer when access to meters cannot be gained and the form is not returned in time for the billing operation, an estimated bill may be rendered.

If an actual meter reading cannot be obtained, the utility may render an estimated bill without reading the meter or supplying a meter reading form to the customer. Only in unusual cases or when approval is obtained from the customer shall more than three consecutive estimated bills be rendered.

20.3(7) *Demand meter registration.* When a demand meter is used for billing, the meter installation should be designed so that the highest expected annual demand reading to be used for billing will appear in the upper half of the meter's range.

20.3(8) *Service areas.* Service areas are defined by the boundaries on service area maps, available for viewing during regular business hours at the board's offices, and available for purchase at the cost of reproduction. These service area maps are adopted as part of this rule and are incorporated in this rule by this reference.

20.3(9) *Petition for modification of service area and answers.* An exclusive service area is subject to modification through a contested case proceeding which may be commenced by filing a petition for modification of service area with the board. The board may commence a service area modification proceeding on its own motion.

Any electric utility or municipal corporation may file a petition for modification of service area which shall contain a legal description of the service area desired, a designation of the utilities involved in each boundary section, and a justification for the proposed service area modification. The justification shall include a detailed statement of why the proposed modification is in the public interest. A map showing the affected areas which complies with subrule 20.3(11)*"a"* shall be attached to the petition as an exhibit. The petition shall be delivered by the United States Postal Service or personal service and shall be considered as filed with the agency on the date of the postmark or the date of personal service.

Copies of the petition shall be served on all utilities involved and the consumer advocate. Those utilities and the consumer advocate shall be parties of record to the proceeding.

All parties shall file an answer which complies with 199—subrule 7.5(1).

20.3(10) *Certificate of authority.* Any electric utility or municipal corporation requesting a service territory modification pursuant to subrule 20.3(9) which would result in service to a customer by a utility other than the utility currently serving the customer must also petition the board for a certificate of authority under Iowa Code section 476.23. The electric utility or municipal corporation shall pay the party currently serving the customer a reasonable price for the facilities serving the customer.

20.3(11) *Maps.*

a. Each utility shall maintain a current map or set of maps showing the physical location of electric lines, stations, and electric transmission facilities for its service areas. The maps shall include the exact location of the following:

(1) Generating stations with capacity designation.

(2) Purchased power supply points with maximum contracted capacity designation.

(3) Purchased power metering points if located at other than power delivery points.

(4) Transmission lines with size and type of conductor designation and operating voltage designation.

(5) Transmission-to-transmission voltage transformation substations with transformer voltage and capacity designation.

(6) Transmission-to-distribution voltage transformation substations with transformer voltage and capacity designation.

(7) Distribution lines with size and type of conductor designation, phase designation and voltage designation.

(8) All points at which transmission, distribution or secondary lines of the utility cross Iowa state boundaries.

(9) All current information required in Iowa Code section 476.24(1).

(10) All county boundaries and county names.

(11) Natural and artificial lakes which cover more than 50 acres and all rivers.

(12) Any additional information required by the board.

b. All maps shall be available for examination at the utility's designated offices during the utility's regular office hours. The maps shall be drawn with clean, uniform lines to a scale of one inch per mile. A large scale shall be used where it is necessary to clarify areas where there is a heavy concentration of facilities. All cartographic details shall be clean cut, and the background shall contain little or no coloration or shading.

20.3(12) Rescinded, IAB 6/29/88, effective 8/3/88.

20.3(13) *Plant additions, electrical line extensions and service lines.*

a. Definitions. The following definitions shall apply to the terms used in this subrule:

"Advance for construction," as used in this subrule, means cash payments or equivalent surety made to the utility by an applicant for an extensive plant addition or an electrical line extension, portions of which may be refunded depending on the attachment of any subsequent service line made to the extensive plant addition or electrical line extension. Cash payments or equivalent surety shall include a grossed-up amount for the income tax effect of such revenue. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining tax liability.

"Agreed-upon attachment period," as used in this subrule, means a period of not less than 30 days nor more than one year mutually agreed upon by the utility and the applicant within which the customer will attach. If no time period is mutually agreed upon, the agreed-upon attachment period shall be deemed to be 30 days.

"Contribution in aid of construction," as used in this subrule, means a nonrefundable cash payment grossed-up for the income tax effect of such revenue covering the costs of an electrical line extension or service line that are in excess of costs paid by the utility. The amount of tax shall be reduced by the present value of the tax benefits to be obtained by depreciating the property in determining the tax liability.

"Electrical line extensions" means distribution line extensions and secondary line extensions as defined in subrule 20.1(3), except for service lines as defined in this subrule.

"Equivalent overhead transformer cost," as used in this subrule, is that transformer capitalized cost, or fraction thereof, that would be required for similarly situated customers served by a pole-mounted or platform-mounted transformer(s). For each overhead service, it shall be the capitalized cost of the transformer(s) divided by the number of customers served by that transformer(s). For each underground service, it shall be the capitalized cost of an overhead transformer(s) with the same voltage and volt-ampere rating divided by the number of customers served by that transformer(s).

"Estimated annual revenues," as used in this subrule, shall be calculated based upon the following factors, including, but not limited to: The size of the facility to be used by the customer, the size and type of equipment to be used by the customer, the average annual amount of service required by the equipment, and the average number of hours per day and days per year the equipment will be in use.

"Estimated base revenues," as used in this subrule, shall be calculated by subtracting the fuel expense costs as described in the uniform system of accounts as adopted by the board and energy efficiency charges from the estimated annual revenues.

"Estimated construction costs," as used in this subrule, shall be calculated using average current costs in accordance with good engineering practices and upon the following factors: amount of service required or desired by the customer requesting the electrical line extension or service line; size, location, and characteristics of the electrical line extension or service line, including appurtenances, except equivalent overhead transformer cost; and whether the ground is frozen or whether other adverse conditions exist. In no event shall estimated construction costs include costs associated with facilities built for the convenience of the utility. The customer shall be charged actual permit fees in addition to estimated construction costs. Permit fees are to be paid regardless of whether the customer is required

to pay an advance for construction or a nonrefundable contribution in aid of construction, and the cost of any permit fee is not refundable.

"Plant addition," as used in this subrule, means any additional plant required to be constructed to provide service to a customer other than an electrical line extension or service line.

"Point of attachment" is that point of first physical attachment of the utilities' service drop (overhead) or service lateral (underground) conductors to the customer's service entrance conductors. For overhead services it shall be the point of tap or splice to the service entrance conductors. For underground services it shall be the point of tap or splice to the service entrance conductors in a terminal box or meter or other enclosure with adequate space inside or outside the building wall. If there is no terminal box, meter, or other enclosure with adequate space, it shall be the point of entrance into the building.

"Service line," as used in this subrule, means any secondary line extension, as defined in subrule 20.1(3), on private property serving a single customer or point of attachment of electric service.

"Similarly situated customer," as used in this subrule, means a customer whose annual consumption or service requirements, as defined by estimated annual revenue, are approximately the same as the annual consumption or service requirements of other customers.

"Utility," as used in this subrule, means a rate-regulated utility.

b. Plant additions. The utility shall provide all electric plant at its cost and expense without requiring an advance for construction from customers or developers except in those unusual circumstances where extensive plant additions are required before the customer can be served. A written contract between the utility and the customer which requires an advance for construction by the customer to make plant additions shall be available for board inspection.

c. Electrical line extensions. Where the customer will attach to the electrical line extension within the agreed-upon attachment period after completion of the electrical line extension, the following shall apply:

(1) The utility shall finance and make the electrical line extension for a customer without requiring an advance for construction if the estimated construction costs to provide an electrical line extension are less than or equal to three times estimated base revenue calculated on the basis of similarly situated customers. The utility may use a feasibility model, rather than three times estimated base revenue, to determine what, if any, advance for construction is required by the customer. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. Whether or not the construction of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(2) If the estimated construction cost to provide an electrical line extension is greater than three times estimated base revenue calculated on the basis of similarly situated customers, the applicant for the electrical line extension shall contract with the utility and make, no more than 30 days prior to commencement of construction, an advance for construction equal to the estimated construction cost less three times estimated base revenue to be produced by the customer. The utility may use a feasibility model to determine whether an advance for construction is required. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(3) Where the customer will not attach within the agreed-upon attachment period after completion of the electrical line extension, the applicant for the electrical line extension shall contract with the utility and make, no more than 30 days prior to the commencement of construction, an advance for construction equal to the estimated construction cost. The utility may use a feasibility model to determine the amount of the advance for construction. The utility shall file a summary explaining the inputs into the feasibility model and a description of the model as part of the utility's tariff. A written contract between the utility and the customer shall be available for board inspection upon request. Whether or not the construction

of the electrical line extension would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees, and the permit fees are not refundable.

(4) Advances for construction may be paid by cash or equivalent surety and shall be refundable for ten years. The customer has the option of providing an advance for construction by cash or equivalent surety unless the utility determines that the customer has failed to comply with the conditions of a surety in the past.

(5) Refunds. When the customer is required to make an advance for construction, the utility shall refund to the depositor for a period of ten years from the date of the original advance a pro-rata share for each service line attached to the electrical line extension. The pro-rata refund shall be computed in the following manner:

1. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the electrical line extension and each service line attached to the electrical line extension exceeds the total estimated constriction cost to provide the electrical line extension, the entire amount of the advance for construction provided shall be refunded.

2. If the combined total of three times estimated base revenue, or the amount allowed by the feasibility model, for the electrical line extension and each service line attached to the electrical line extension is less than the total estimated construction cost to provide the electrical line extension, the amount to be refunded shall equal three times estimated base revenue, or the amount allowed by the feasibility model, when a service line is attached to the electrical line extension.

3. In no event shall the total amount to be refunded exceed the amount of the advance for construction. Any amounts subject to refund shall be paid by the utility without interest. At the expiration of the above-described ten-year period, the advance for construction record shall be closed and the remaining balance shall be credited to the respective plant account.

(6) The utility shall keep a record of each work order under which the electrical line extension was installed, to include the estimated revenues, the estimated construction costs, the amount of any payment received, and any refunds paid.

d. Service lines.

(1) The utility shall finance and construct either an overhead or underground service line without requiring a nonrefundable contribution in aid of construction or any payment by the applicant where the length of the overhead service line to the first point of attachment is up to 50 feet on private property or where the cost of the underground service line to the meter or service disconnect is less than or equal to the estimated cost of constructing an equivalent overhead service line of up to 50 feet.

(2) Where the length of the overhead service line exceeds 50 feet on private property, the applicant shall be required to provide a nonrefundable contribution in aid of construction for that portion of the service line on private property, exclusive of the point of attachment, within 30 days after completion. The nonrefundable contribution in aid of construction for that portion of the service line shall be computed as follows:

$$\text{(Estimated Construction Costs)} \times \frac{\text{(Total Length in Excess of 50 Feet)}}{\text{(Total Length of Service Line)}}$$

(3) Where the cost of the underground service line exceeds the estimated cost of constructing an equivalent overhead service line of up to 50 feet, the applicant shall be required to provide a nonrefundable contribution in aid of construction within 30 days after completion equal to the difference between the estimated cost of constructing the underground service line and the estimated cost of constructing an equivalent overhead service line of up to 50 feet.

(4) A utility may adopt a tariff or rule that allows the utility to finance and construct a service line of more than 50 feet without requiring a nonrefundable contribution in aid of construction from the customer if the tariff or rule applies equally to all customers or members.

(5) Whether or not the construction of the service line would otherwise require a payment from the customer, the utility shall charge the customer for actual permit fees.

e. Extensions not required. Utilities shall not be required to make electrical line extensions or install service lines as described in this subrule, unless the electrical line extension or service line shall be of a permanent nature.

f. Different payment arrangement. This subrule shall not be construed as prohibiting any utility from making a contract with a customer using a different payment arrangement, if the contract provides a more favorable payment arrangement to the customer, so long as no discrimination is practiced among customers.

This rule is intended to implement Iowa Code section 476.8.

[**ARC 7584B**, IAB 2/25/09, effective 4/1/09]

199—20.4(476) Customer relations.

20.4(1) *Customer information.* Each utility shall:

a. Maintain up-to-date maps, plans, or records of its entire transmission and distribution systems, together with such other information as may be necessary to enable the utility to advise prospective customers, and others entitled to the information, as to the facilities available for serving prospective customers in its service area.

b. Assist the customer or prospective customer in selecting the most economical rate schedule available for the customer's proposed type of service.

c. Notify customers affected by a change in rates or schedule classification in the manner provided in the rules of practice and procedure before the board. [199—7.4(476)IAC]

d. Post a notice in a conspicuous place in each office of the utility where applications for service are received, informing the public that copies of the rate schedules and rules relating to the service of the utility, as filed with the board, are available for public inspection. If the utility has provided access to its rate schedules and rules for service on its Web site, the notice should include the Web site address.

e. Upon request, inform its customers as to the method of reading meters.

f. State, on the bill form, that tariff and rate schedule information is available upon request at the utility's local business office.

g. Upon request, transmit a statement of either the customer's actual consumption, or degree day adjusted consumption, at the company's option, of electricity for each billing during the prior 12 months.

h. Furnish such additional information as the customer may reasonably request.

20.4(2) *Customer contact employee qualifications.* Each utility shall promptly and courteously resolve inquiries for information or complaints. Employees who receive customer telephone calls and office visits shall be qualified and trained in screening and resolving complaints, to avoid a preliminary recitation of the entire complaint to employees without ability and authority to act. The employee shall provide identification to the customer that will enable the customer to reach that employee again if needed.

Each utility shall notify its customers, by bill insert or notice on the bill form, of the address and telephone number where a utility representative qualified to assist in resolving the complaint can be reached. The bill insert or notice shall also include the following statement: "If (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)281-3839, or toll-free 1-877-565-4450, or by writing to 350 Maple Street, Des Moines, Iowa 50319, or by E-mail to iubcustomer@iub.state.ia.us."

The bill insert or notice for municipal utilities shall include the following statement: "If your complaint is related to service disconnection, safety, or renewable energy, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)281-3839, or toll-free 1-877-565-4450, by writing to 350 Maple Street, Des Moines, Iowa 50319, or by E-mail to iubcustomer@iub.state.ia.us."

The bill insert or notice for non-rate-regulated rural electric cooperatives shall include the following statement: "If your complaint is related to the (utility name) service rather than its rates, and (utility name) does not resolve your complaint, you may request assistance from the Iowa Utilities Board by calling (515)281-3839, or toll-free 1-877-565-4450, by writing to 350 Maple Street, Des Moines, Iowa 50319, or by E-mail to iubcustomer@iub.state.ia.us."

The bill insert or notice on the bill shall be provided monthly by utilities serving more than 50,000 Iowa retail customers and no less than annually by all other electric utilities. Any utility which does not use the standard statement described in this subrule shall file its proposed statement in its tariff for approval. A utility that bills by postcard may place an advertisement in a local newspaper of general circulation or a customer newsletter instead of a mailing. The advertisement must be of a type size that is easily legible and conspicuous and must contain the information set forth above.

20.4(3) *Customer deposits.*

a. Each utility may require from any customer or prospective customer a deposit intended to guarantee partial payment of bills for service. Each utility shall allow a person other than the customer to pay the customer's deposit. In lieu of a cash deposit, the utility may accept the written guarantee of a surety or other responsible party as surety for an account. Upon termination of a guarantee contract, or whenever the utility deems the contract insufficient as to amount or surety, a cash deposit or a new or additional guarantee may be required for good cause upon reasonable written notice.

b. A new or additional deposit may be required from a customer when a deposit has been refunded or is found to be inadequate. Written notice shall be mailed advising the customer of any new or additional deposit requirement. The customer shall have no less than 12 days from the date of mailing to comply. The new or additional deposit shall be payable at any of the utility's business offices or local authorized agents. An appropriate receipt shall be provided. No written notice is required to be given of a deposit required as a prerequisite for commencing initial service.

c. No deposit shall be required as a condition for service other than determined by application of either credit rating or deposit calculation criteria, or both, of the filed tariff.

d. The total deposit for any residential or commercial customer for a place which has previously received service shall not be greater than the highest billing of service for one month for the place in the previous 12-month period. The deposit for any residential or commercial customer for a place which has not previously received service, or for an industrial customer, shall be the customer's projected one-month usage for the place to be served as determined by the utility, or as may be reasonably required by the utility in cases involving service for short periods or special occasions.

20.4(4) *Interest on customer deposits.* Interest shall be paid by the rate-regulated utility to each customer required to make a deposit. On or after April 21, 1994, rate-regulated utilities shall compute interest on customer deposits at 7.5 percent per annum, compounded annually. Interest for prior periods shall be computed at the rate specified by the rule in effect for the period in question. Interest shall be paid for the period beginning with the date of deposit to the date of refund or to the date that the deposit is applied to the customer's account, or to the date the customer's bill becomes permanently delinquent. The date of refund is that date on which the refund or the notice of deposit refund is forwarded to the customer's last-known address. The date a customer's bill becomes permanently delinquent, relative to an account treated as an uncollectible account, is the most recent date the account became delinquent.

20.4(5) *Customer deposit records.* Each utility shall keep records to show:

a. The name and address of each depositor.

b. The amount and date of the deposit.

c. Each transaction concerning the deposit.

20.4(6) *Customer's receipt for a deposit.* Each utility shall issue a receipt of deposit to each customer from whom a deposit is received, and shall provide means whereby a depositor may establish claim if the receipt is lost.

20.4(7) *Deposit refund.* A deposit shall be refunded after 12 consecutive months of prompt payment (which may be 11 timely payments and 1 automatic forgiveness of late payment). For refund purposes the account shall be reviewed for prompt payment after 12 months of service following the making of the deposit and for each 12-month interval terminating on the anniversary of the deposit. However, deposits received from customers subject to the exemption provided by 20.4(3)*"b,"* including surety deposits, may be retained by the utility until final billing. Upon termination of service, the deposit plus accumulated interest, less any unpaid utility bill of the customer, shall be reimbursed to the person who made the deposit.

20.4(8) *Unclaimed deposits.* The utility shall make a reasonable effort to return each unclaimed deposit and accrued interest after the termination of the services for which the deposit was made. The utility shall maintain a record of deposit information for at least two years or until such time as the deposit, together with accrued interest, escheats to the state pursuant to Iowa Code section 556.4, at which time the record and deposit, together with accrued interest less any lawful deductions, shall be sent to the state treasurer pursuant to Iowa Code section 556.11.

20.4(9) *Customer bill forms.* Each customer shall be informed as promptly as possible following the reading of the customer's meter, on bill form or otherwise, of the following:

a. The reading of the meter at the beginning and at the end of the period for which the bill is rendered.

b. The dates on which the meter was read, at the beginning and end of the billing period.

c. The number and kind of units metered.

d. The applicable rate schedule, or identification of the applicable rate schedule.

e. The account balance brought forward and amount of each net charge for rate-schedule-priced utility service, sales tax, other taxes, late payment charge, and total amount currently due. In the case of prepayment meters, the amount of money collected shall be shown.

f. The last date for timely payment shall be clearly shown and shall be not less than 20 days after the bill is rendered.

g. A distinct marking to identify an estimated bill.

h. A distinct marking to identify a minimum bill.

i. Any conversions from meter reading units to billing units, or any calculations to determine billing units from recording or other devices, or any other factors, such as sliding scale or automatic adjustment and amount of sales tax adjustments used in determining the bill.

j. Customer billing information alternate. A utility serving less than 5000 electric customers may provide the information in 20.4(9) on bill form or otherwise. If the utility elects not to provide the information of 20.4(9), it shall advise the customer, on bill form or by bill insert, that such information can be obtained by contacting the utility's local office.

20.4(10) Rescinded, effective 7/1/81.

20.4(11) *Payment agreements.*

a. Availability of a first payment agreement. When a residential customer cannot pay in full a delinquent bill for utility service or has an outstanding debt to the utility for residential utility service and is not in default of a payment agreement with the utility, a utility shall offer the customer an opportunity to enter into a reasonable payment agreement.

b. Reasonableness. Whether a payment agreement is reasonable will be determined by considering the current household income, ability to pay, payment history including prior defaults on similar agreements, the size of the bill, the amount of time and the reasons why the bill has been outstanding, and any special circumstances creating extreme hardships within the household. The utility may require the person to confirm financial difficulty with an acknowledgment from the department of human services or another agency.

c. Terms of payment agreements.

(1) *First payment agreement.* The utility shall offer customers who have received a disconnection notice or have been disconnected 120 days or less and who are not in default of a payment agreement the option of spreading payments evenly over at least 12 months by paying specific amounts at scheduled times. The utility shall offer customers who have been disconnected more than 120 days and who are not in default of a payment agreement the option of spreading payments evenly over at least 6 months by paying specific amounts at scheduled times.

1. The agreement shall also include provision for payment of the current account. The agreement negotiations and periodic payment terms shall comply with tariff provisions which are consistent with these rules. The utility may also require the customer to enter into a level payment plan to pay the current bill.

2. When the customer makes the agreement in person, a signed copy of the agreement shall be provided to the customer.

3. The utility may offer the customer the option of making the agreement over the telephone or through electronic transmission. When the customer makes the agreement over the telephone or through electronic transmission, the utility shall render to the customer a written document reflecting the terms and conditions of the agreement within three days of the date the parties entered into the oral agreement or electronic agreement. The document will be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the document shall be considered rendered to the customer when delivered to the last-known address of the person responsible for payment for the service. The document shall state that unless the customer notifies the utility within ten days from the date the document is rendered, it will be deemed that the customer accepts the terms as reflected in the written document. The document stating the terms and agreements shall include the address and a toll-free or collect telephone number where a qualified representative can be reached. By making the first payment, the customer confirms acceptance of the terms of the oral agreement or electronic agreement.

4. Each customer entering into a first payment agreement shall be granted at least one late payment that is made four days or less beyond the due date for payment and the first payment agreement shall remain in effect.

(2) *Second payment agreement.* The utility shall offer a second payment agreement to a customer who is in default of a first payment agreement if the customer has made at least two consecutive full payments under the first payment agreement. The second payment agreement shall be for the same term as or longer than the term of the first payment agreement. The customer shall be required to pay for current service in addition to the monthly payments under the second payment agreement and may be required to make the first payment up-front as a condition of entering into the second payment agreement. The utility may also require the customer to enter into a level payment plan to pay the current bill. The utility may offer additional payment agreements to the customer.

d. Refusal by utility. A customer may offer the utility a proposed payment agreement. If the utility and the customer do not reach an agreement, the utility may refuse the offer orally, but the utility must render a written refusal to the customer, stating the reason for the refusal, within three days of the oral notification. The written refusal shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the written refusal shall be considered rendered to the customer when handed to the customer or when delivered to the last-known address of the person responsible for the payment for the service.

A customer may ask the board for assistance in working out a reasonable payment agreement. The request for assistance must be made to the board within ten days after the rendering of the written refusal. During the review of this request, the utility shall not disconnect the service.

20.4(12) *Bill payment terms.* The bill shall be considered rendered to the customer when deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the bill shall be considered rendered when delivered to the last-known address of the party responsible for payment. There shall not be less than 20 days between the rendering of a bill and the date by which the account becomes delinquent. Bills for customers on more frequent billing intervals under subrule 20.3(6) may not be considered delinquent less than 5 days from the date of rendering. However, a late payment charge may not be assessed if payment is received within 20 days of the date the bill is rendered.

a. The date of delinquency for all residential customers or other customers whose consumption is less than 3,000 kWh per month, shall be changeable for cause in writing; such as, but not limited to, 15 days from approximate date each month upon which income is received by the person responsible for payment. In no case, however, shall the utility be required to delay the date of delinquency more than 30 days beyond the date of preparation of the previous bill.

b. In any case where net and gross amounts are billed to customers, the difference between net and gross is a late payment charge and is valid only when part of a delinquent bill payment. A utility's late payment charge shall not exceed 1.5 percent per month of the past due amount. No collection fee may be levied in addition to this late payment charge. This rule does not prohibit cost-justified charges for disconnection and reconnection of service.

c. If the customer makes partial payment in a timely manner, and does not designate the service or product for which payment is made, the payment shall be credited pro rata between the bill for utility services and related taxes.

d. Each account shall be granted not less than one complete forgiveness of a late payment charge each calendar year. The utility's rules shall be definitive that on one monthly bill in each period of eligibility, the utility will accept the net amount of such bill as full payment for such month after expiration of the net payment period. The rules shall state how the customer is notified that the eligibility has been used. Complete forgiveness prohibits any effect upon the credit rating of the customer or collection of late payment charge.

e. Level payment plan. Utilities shall offer a level payment plan to all residential customers or other customers whose consumption is less than 3,000 kWh per month. A level payment plan should be designed to limit the volatility of a customer's bill and maintain reasonable account balances. The level payment plan shall include at least the following:

(1) Be offered to each eligible customer when the customer initially requests service.

(2) Allow for entry into the level payment plan anytime during the calendar year.

(3) Provide that a customer may request termination of the plan at any time. If the customer's account is in arrears at the time of termination, the balance shall be due and payable at the time of termination. If there is a credit balance, the customer shall be allowed the option of obtaining a refund or applying the credit to future charges. A utility is not required to offer a new level payment plan to a customer for six months after the customer has terminated from a level payment plan.

(4) Use a computation method that produces a reasonable monthly level payment amount, which may take into account forward-looking factors such as fuel price and weather forecasts, and that complies with requirements in 20.4(12)*"e"*(4). The computation method used by the utility shall be described in the utility's tariff and shall be subject to board approval. The utility shall give notice to customers when it changes the type of computation method in the level payment plan.

The amount to be paid at each billing interval by a customer on a level payment plan shall be computed at the time of entry into the plan and shall be recomputed at least annually. The level payment amount may be recomputed monthly, quarterly, when requested by the customer, or whenever price, consumption, or a combination of factors results in a new estimate differing by 10 percent or more from that in use.

When the level payment amount is recomputed, the level payment plan account balance shall be divided by 12, and the resulting amount shall be added to the estimated monthly level payment amount. Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be given the option of applying any credit to payments of subsequent months' level payment amounts due or of obtaining a refund of any credit in excess of $25.

Except when a utility has a level payment plan that recomputes the level payment amount monthly, the customer shall be notified of the recomputed payment amount not less than one full billing period prior to the date of delinquency for the recomputed payment. The notice may accompany the bill prior to the bill that is affected by the recomputed payment amount.

(5) Irrespective of the account balance, a delinquency in payment shall be subject to the same collection and disconnection procedures as other accounts, with the late payment charge applied to the level payment amount. If the account balance is a credit, the level payment plan may be terminated by the utility after 30 days of delinquency.

20.4(13) *Customer records.* The utility shall retain records as may be necessary to effectuate compliance with 20.4(14) and 20.6(6), but not less than three years. Records for customer shall show where applicable:

a. kWh meter reading
b. kWh consumption
c. kW meter reading
d. kW measured demand
e. kW billing demand
f. Total amount of bill.

20.4(14) *Adjustment of bills.*

a. Meter error. Whenever a meter creeps or whenever a metering installation is found upon any test to have an average error of more than 2.0 percent for watthour metering; or a demand metering error of more than 1.5 percent in addition to the errors allowed under accuracy of demand metering; an adjustment of bills for service for the period of inaccuracy shall be made in the case of overregistration and may be made in the case of underregistration. The amount of the adjustment shall be calculated on the basis that the metering equipment should be 100 percent accurate with respect to the testing equipment used to make the test. For watthour metering installations the average accuracy shall be the arithmetic average of the percent registration at 10 percent of rated test current and at 100 percent of rated test current giving the 100 percent of rated test current registration a weight of four and the 10 percent of rated test current registration a weight of one.

b. Determination of adjustment. Recalculation of bills shall be on the basis of actual monthly consumption except that if service has been measured by self-contained single-phase meters or three-wire network meters and involves no billing other than for kilowatt-hours, the recalculation of bills may be based on the average monthly consumption determined from the most recent 36 months, consumption data.

When the average error cannot be determined by test because of failure of part or all of the metering equipment, it shall be permissible to use the registration of check metering installations, if any, or to estimate the quantity of energy consumed based on available data. The customer must be advised of the failure and of the basis for the estimate of quantity billed. The periods of error shall be used as defined in immediately following subparagraphs (1) and (2).

(1) Overregistration. If the date when overregistration began can be determined, such date shall be the starting point for determination of the amount of the adjustment. If the date when overregistration began cannot be determined, it shall be assumed that the error has existed for the shortest time period calculated as one-half the time since the meter was installed, or one-half the time elapsed since the last meter test unless otherwise ordered by the board.

The overregistration due to creep shall be calculated by timing the rate of creeping and assuming that the creeping affected the registration of the meter for 25 percent of the time since the more recent of either metering installation or last previous test.

(2) Underregistration. If the date when underregistration began can be determined, it shall be the starting point for determination of the amount of the adjustment except that billing adjustment shall be limited to the preceding six months. If the date when underregistration began cannot be determined, it shall be assumed that the error has existed for one-half of the time elapsed since the more recent of either meter installation or the last meter test, except that billing adjustment shall be limited to the preceding six months unless otherwise ordered by the board.

The underregistration due to creep shall be calculated by timing the rate of creeping and assuming that this creeping affected the registration for 25 percent of the time since the more recent of either metering installation or last previous test, except that billing adjustment shall be limited to the preceding six months.

c. Refunds. If the recalculated bills indicate that $5 or more is due an existing customer or $10 or more is due a person no longer a customer of the utility, the tariff shall provide refunding of the full amount of the calculated difference between the amount paid and the recalculated amount. Refunds shall be made to the two most recent customers who received service through the metering installation found to be in error. In the case of a previous customer who is no longer a customer of the utility, a notice of the amount subject to refund shall be mailed to such previous customer at the last-known address, and the utility shall, upon demand made within three months thereafter, refund the same.

Refunds shall be completed within six months following the date of the metering installation test.

d. Back billing. A utility may not back bill due to underregistration unless a minimum back bill amount is specified in its tariff. The minimum amount specified for back billing shall not be less than, but may be greater than, $5 for an existing customer or $10 for a former customer. All recalculations resulting in an amount due equal or greater than the tariff specified minimum shall result in issuance of a back bill.

Back billings shall be rendered no later than six months following the date of the metering installation test.

e. Overcharges. When a customer has been overcharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the metering installation or other similar reasons, the amount of the overcharge shall be adjusted, refunded or credited to the customer. The time period for which the utility is required to adjust, refund, or credit the customer's bill shall not exceed five years unless otherwise ordered by the board.

f. Undercharges. When a customer has been undercharged as a result of incorrect reading of the meter, incorrect application of the rate schedule, incorrect connection of the meter or other similar reasons, the amount of the undercharge may be billed to the customer. The period for which the utility may adjust for the undercharge shall not exceed five years unless otherwise ordered by the board. The maximum back bill shall not exceed the dollar amount equivalent to the tariffed rate for like charges (e.g., usage-based, fixed or service charges) in the 12 months preceding discovery of the error unless otherwise ordered by the board.

g. Credits and explanations. Credits due a customer because of meter inaccuracies, errors in billing, or misapplication of rates shall be separately identified.

20.4(15) *Refusal or disconnection of service.* A utility shall refuse service or disconnect service to a customer, as defined in subrule 20.1(3), in accordance with tariffs that are consistent with these rules.

a. The utility shall give written notice of pending disconnection except as specified in paragraph 20.4(15)*"b."* The notice shall set forth the reason for the notice and the final date by which the account is to be settled or specific action taken. The notice shall be considered rendered to the customer when addressed to the customer's last-known address and deposited in the U.S. mail with postage prepaid. If delivery is by other than U.S. mail, the notice shall be considered rendered when delivered to the last-known address of the person responsible for payment for the service. The date for disconnection of service shall be not less than 12 days after the notice is rendered. The date for disconnection of service for customers on shorter billing intervals under subrule 20.3(6) shall not be less than 24 hours after the notice is posted at the service premises.

One written notice, including all reasons for the notice, shall be given where more than one cause exists for disconnection of service. In determining the final date by which the account is to be settled or other specific action taken, the days of notice for the causes shall be concurrent.

b. Service may be disconnected without notice:

(1) In the event of a condition on the customer's premises determined by the utility to be hazardous.

(2) In the event of customer use of equipment in a manner which adversely affects the utility's equipment or the utility's service to others.

(3) In the event of tampering with the equipment furnished and owned by the utility. For the purposes of this subrule, a broken or absent meter seal alone shall not constitute tampering.

(4) In the event of unauthorized use.

c. Service may be disconnected or refused after proper notice:

(1) For violation of or noncompliance with the utility's rules on file with the board.

(2) For failure of the customer to furnish the service equipment, permits, certificates, or rights-of-way which are specified to be furnished, in the utility's rules filed with the board, as conditions of obtaining service, or for the withdrawal of that same equipment, or for the termination of those same permissions or rights, or for the failure of the customer to fulfill the contractual obligations imposed as conditions of obtaining service by any contract filed with and subject to the regulatory authority of the board.

(3) For failure of the customer to permit the utility reasonable access to the utility's equipment.

d. Service may be refused or disconnected after proper notice for nonpayment of a bill or deposit, except as restricted by subrules 20.4(16) and 20.4(17), provided that the utility has complied with the following provisions when applicable:

(1) Given the customer a reasonable opportunity to dispute the reason for the disconnection or refusal.

(2) Given the customer, and any other person or agency designated by the customer, written notice that the customer has at least 12 days in which to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities available. Customers billed more frequently than monthly pursuant to subrule 20.3(6) shall be given posted written notice that they have 24 hours to make settlement of the account to avoid disconnection and a written summary of the rights and responsibilities. All written notices shall include a toll-free or collect telephone number where a utility representative qualified to provide additional information about the disconnection can be reached. Each utility representative must provide the representative's name and have immediate access to current, detailed information concerning the customer's account and previous contacts with the utility.

(3) The summary of the rights and responsibilities must be approved by the board. Any utility providing electric service and defined as a public utility in Iowa Code section 476.1 which does not use the standard form set forth below for customers billed monthly shall submit to the board an original and six copies of its proposed form for approval. A utility billing a combination customer for both gas and electric service may modify the standard form to replace each use of the word "electric" with the words "gas and electric" in all instances.

CUSTOMER RIGHTS AND RESPONSIBILITIES TO AVOID SHUTOFF OF ELECTRIC SERVICE FOR NONPAYMENT

1. What can I do if I receive a notice from the utility that says my service will be shut off because I have a past due bill?

a. Pay the bill in full; or

b. Enter into a reasonable payment plan with the utility (see #2 below); or

c. Apply for and become eligible for low-income energy assistance (see #3 below); or

d. Give the utility a written statement from a doctor or public health official stating that shutting off your electric service would pose an especial health danger for a person living at the residence (see #4 below); or

e. Tell the utility if you think part of the amount shown on the bill is wrong. However, you must still pay the part of the bill you agree you owe the utility (see #5 below).

2. How do I go about making a reasonable payment plan? (Residential customers only)

a. Contact the utility as soon as you know you cannot pay the amount you owe. If you cannot pay all the money you owe at one time, the utility may offer you a payment plan that spreads payments evenly over at least 12 months. The plan may be longer depending on your financial situation.

b. If you have not made the payments you promised in a previous payment plan with the utility and still owe money, you may qualify for a second payment agreement under certain conditions.

c. If you do not make the payments you promise, the utility may shut off your utility service on one day's notice unless all the money you owe the utility is paid or you enter into another payment agreement.

3. How do I apply for low-income energy assistance? (Residential customers only)

a. Contact the local community action agency in your area (see attached list); or

b. Contact the Division of Community Action Agencies at the Iowa Department of Human Rights, Lucas State Office Building, Des Moines, Iowa 50319; telephone (515)281-0859. To prevent disconnection, you must contact the utility prior to disconnection of your service.

c. To avoid disconnection, you must apply for energy assistance before your service is shut off. Notify your utility that you may be eligible and have applied for energy assistance. Once your service has been disconnected, it will not be reconnected based on approval for energy assistance.

d. Being certified eligible for energy assistance will prevent your service from being disconnected from November 1 through April 1.

4. What if someone living at the residence has a serious health condition? (Residential customers only)

Contact the utility if you believe this is the case. Contact your doctor or a public health official and ask the doctor or health official to contact the utility and state that shutting off your utility service would pose an especial health danger for a person living at your residence. The doctor or public health official must provide a written statement to the utility office within 5 days of when your doctor or public health official notifies the utility of the health condition; otherwise, your utility service may be shut off. If the

utility receives this written statement, your service will not be shut off for 30 days. This 30-day delay is to allow you time to arrange payment of your utility bill or find other living arrangements. After 30 days, your service may be shut off if payment arrangements have not been made.

5. What should I do if I believe my bill is not correct?

You may dispute your utility bill. You must tell the utility that you dispute the bill. You must pay the part of the bill you think is correct. If you do this, the utility will not shut off your service for 45 days from the date the bill was mailed while you and the utility work out the dispute over the part of the bill you think is incorrect. You may ask the Iowa Utilities Board for assistance in resolving the dispute. (See #9 below.)

6. When can the utility shut off my utility service because I have not paid my bill?

a. Your utility can shut off service between the hours of 6 a.m. and 2 p.m., Monday through Friday.

b. The utility will not shut off your service on nights, weekends, or holidays for nonpayment of a bill.

c. The utility will not shut off your service if you enter into a reasonable payment plan to pay the overdue amount (see #2 above).

d. The utility will not shut off your service if the temperature is forecasted to be 20 degrees Fahrenheit or colder during the following 24-hour period, including the day your service is scheduled to be shut off.

e. If you have qualified for low-income energy assistance, the utility cannot shut off your service from November 1 through April 1. However, you will still owe the utility for the service used during this time.

f. The utility will not shut off your service if you have notified the utility that you dispute a portion of your bill and you pay the part of the bill that you agree is correct.

7. How will I be told the utility is going to shut off my service?

a. You must be given a written notice at least 12 days before the utility service can be shut off for nonpayment. This notice will include the reason for shutting off your service.

b. If you have not made payments required by an agreed-upon payment plan, your service may be disconnected with only one day's notice.

c. The utility must also try to reach you by telephone or in person before it shuts off your service. From November 1 through April 1, if the utility cannot reach you by telephone or in person, the utility will put a written notice on the door of your residence to tell you that your utility service will be shut off.

8. If service is shut off, when will it be turned back on?

a. The utility will turn your service back on if you pay the whole amount you owe or agree to a reasonable payment plan (see #2 above).

b. If you make your payment during regular business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after regular business hours, the utility must make a reasonable effort to turn your service back on that day. If service cannot reasonably be turned on that same day, the utility must do it by 11 a.m. the next day.

c. The utility may charge you a fee to turn your service back on. Those fees may be higher in the evening or on weekends, so you may ask that your service be turned on during normal utility business hours.

9. Is there any other help available besides my utility?

If the utility has not been able to help you with your problem, you may contact the Iowa Utilities Board toll-free at 1-877-565-4450. You may also write the Iowa Utilities Board at 350 Maple Street, Des Moines, Iowa 50319-0069, or by E-mail at iubcustomer@iub.state.ia.us. Low-income customers may also be eligible for free legal assistance from Iowa Legal Aid, and may contact Legal Aid at 1-800-532-1275.

(4) If the utility has adopted a service limitation policy pursuant to subrule 20.4(23), the following paragraph shall be appended to the end of the standard form for the summary of rights and remedies, as set forth in subparagraph 20.4(15)*"d"*(3):

Service limitation: We have adopted a policy of service limitation before disconnection. You may be qualified for service limitation rather than disconnection. To see if you qualify, contact our business office.

(5) When disconnecting service to a residence, made a diligent attempt to contact, by telephone or in person, the customer responsible for payment for service to the residence to inform the customer of the pending disconnection and the customer's rights and responsibilities. During the period from November 1 through April 1, if the attempt at customer contact fails, the premises shall be posted at least one day prior to disconnection with a notice informing the customer of the pending disconnection and rights and responsibilities available to avoid disconnection.

If an attempt at personal or telephone contact of a customer occupying a rental unit has been unsuccessful, the landlord of the rental unit, if known, shall be contacted to determine if the customer is still in occupancy and, if so, the customer's present location. The landlord shall also be informed of the date when service may be disconnected.

If the disconnection will affect occupants of residential units leased from the customer, the premises of any building known by the utility to contain residential units affected by disconnection must be posted, at least two days prior to disconnection, with a notice informing any occupants of the date when service will be disconnected and the reasons for the disconnection.

(6) Disputed bill. If the customer has received notice of disconnection and has a dispute concerning a bill for electric utility service, the utility may require the customer to pay a sum of money equal to the amount of the undisputed portion of the bill pending settlement and thereby avoid disconnection of service. A utility shall delay disconnection for nonpayment of the disputed bill for up to 45 days after the rendering of the bill if the customer pays the undisputed amount. The 45 days shall be extended by up to 60 days if requested of the utility by the board in the event the customer files a written complaint with the board in compliance with 199—Chapter 6.

(7) Reconnection. Disconnection of a residential customer may take place only between the hours of 6 a.m. and 2 p.m. on a weekday and not on weekends or holidays. If a disconnected customer makes payment or other arrangements during normal business hours, or by 7 p.m. for utilities permitting such payment or other arrangements after normal business hours, all reasonable efforts shall be made to reconnect the customer that day. If a disconnected customer makes payment or other arrangements after 7 p.m., all reasonable efforts shall be made to reconnect the customer not later than 11 a.m. the next day.

(8) Severe cold weather. A disconnection may not take place where electricity is used as the only source of space heating or to control or operate the only space heating equipment at the residence on any day when the National Weather Service forecast for the following 24 hours covering the area in which the residence is located includes a forecast that the temperature will be 20 degrees Fahrenheit or colder. In any case where the utility has posted a disconnect notice in compliance with subparagraph 20.4(15)*"d"*(5) but is precluded from disconnecting service because of a National Weather Service forecast, the utility may immediately proceed with appropriate disconnection procedures, without further notice, when the temperature in the area where the residence is located rises above 20 degrees Fahrenheit and is forecasted to be above 20 degrees Fahrenheit for at least 24 hours, unless the customer has paid in full the past due amount or is entitled to postponement of disconnection under some other provision of paragraph 20.4(15)*"d."*

(9) Health of a resident. Disconnection of a residential customer shall be postponed if the disconnection of service would present an especial danger to the health of any permanent resident of the premises. An especial danger to health is indicated if a person appears to be seriously impaired and may, because of mental or physical problems, be unable to manage the person's own resources, to carry out activities of daily living or to be protected from neglect or hazardous situations without assistance from others. Indicators of an especial danger to health include but are not limited to: age, infirmity, or mental incapacitation; serious illness; physical disability, including blindness and limited mobility; and any other factual circumstances which indicate a severe or hazardous health situation.

The utility may require written verification of the especial danger to health by a physician or a public health official, including the name of the person endangered; a statement that the person is a resident of the premises in question; the name, business address, and telephone number of the certifying party; the nature of the health danger; and approximately how long the danger will continue. Initial verification by the verifying party may be by telephone if written verification is forwarded to the utility within five days.

Verification shall postpone disconnection for 30 days. In the event service is terminated within 14 days prior to verification of illness by or for a qualifying resident, service shall be restored to that residence if a proper verification is thereafter made in accordance with the foregoing provisions. If the customer does not enter into a reasonable payment agreement for the retirement of the unpaid balance of the account within the first 30 days and does not keep the current account paid during the period that the unpaid balance is to be retired, the customer is subject to disconnection pursuant to paragraph 20.4(15)*"f."*

(10) Winter energy assistance (November 1 through April 1). If the utility is informed that the customer's household may qualify for winter energy assistance or weatherization funds, there shall be no disconnection of service for 30 days from the date the utility is notified to allow the customer time to obtain assistance. Disconnection shall not take place from November 1 through April 1 for a resident who is a head of household and who has been certified to the public utility by the community action agency as eligible for either the low-income home energy assistance program or weatherization assistance program.

e. Abnormal electric consumption. A customer who is subject to disconnection for nonpayment of bill, and who has electric consumption which appears to the customer to be abnormally high, may request the utility to provide assistance in identifying the factors contributing to this usage pattern and to suggest remedial measures. The utility shall provide assistance by discussing patterns of electric usage which may be readily identifiable, suggesting that an energy audit be conducted, and identifying sources of energy conservation information and financial assistance which may be available to the customer.

f. A utility may disconnect electric service without the written 12-day notice for failure of the customer to comply with the terms of a payment agreement, except as provided in numbered paragraph 20.4(11)*"c"*(1)"4," provided the utility complies with the provisions of paragraph 20.4(15)*"d."*

g. The utility shall, prior to November 1, mail customers a notice describing the availability of winter energy assistance funds and the application process. The notice must be of a type size that is easily legible and conspicuous and must contain the information set out by the state agency administering the assistance program. A utility serving fewer than 25,000 customers may publish the notice in a customer newsletter in lieu of mailing. A utility serving fewer than 6,000 customers may publish the notice in an advertisement in a local newspaper of general circulation or shopper's guide.

h. A utility may disconnect electric service without the written 12-day notice for failure of a residential customer who has had service limited in accordance with subrule 20.4(23) to pay the full amount due for past service or to enter into a reasonable payment agreement, provided that:

(1) The minimum time period, as specified in the utility's tariff, for the service limiter to remain in place prior to initiation of the disconnection procedure has elapsed;

(2) The requirements of paragraph 20.4(15)*"f,"* relating to in-person, telephone or posted notice, have been satisfied;

(3) The requirements of subparagraphs 20.4(15)*"d"*(7) and (8), relating to time and temperature restrictions on disconnection are satisfied, to the extent applicable; and

(4) The requirements of subparagraph 20.4(15)*"d"*(9), relating to health restrictions on disconnection are satisfied, to the extent applicable.

20.4(16) *Insufficient reasons for denying service.* The following shall not constitute sufficient cause for refusal of service to a customer:

a. Delinquency in payment for service by a previous occupant of the premises to be served.

b. Failure to pay for merchandise purchased from the utility.

c. Failure to pay for a different type or class of public utility service.

d. Failure to pay the bill of another customer as guarantor thereof.

e. Failure to pay the back bill rendered in accordance with paragraph 20.4(14)*"d"* (slow meters).

f. Failure to pay a bill rendered in accordance with paragraph 20.4(14)*"f."*

g. Failure of a residential customer to pay a deposit during the period November 1 through April 1 for the location at which the customer has been receiving service.

h. Delinquency in payment for service by an occupant if the customer applying for service is creditworthy and able to satisfy any deposit requirements.

20.4(17) *When disconnection prohibited.* No disconnection may take place from November 1 through April 1 for a resident who has been certified to the public utility by the local community action agency as being eligible for either the low-income home energy assistance program or weatherization assistance program.

20.4(18) *Estimated demand.* Upon request of the customer and provided the customer's demand is estimated for billing purposes, the utility shall measure the demand during the customer's normal operation and use the measured demand for billing.

20.4(19) *Servicing utilization control equipment.* Each utility shall service and maintain any equipment it uses on customer's premises and shall correctly set and keep in proper adjustment any thermostats, clocks, relays, time switches or other devices which control the customer's service in accordance with the provisions in the utility's rate schedules.

20.4(20) *Customer complaints.* Complaints concerning the charges, practices, facilities or service of the utility shall be investigated promptly and thoroughly. The utility shall keep such records of customer complaints as will enable it to review and analyze its procedures and actions.

a. Each utility shall provide in its filed tariff a concise, fully informative procedure for the resolution of customer complaints.

b. The utility shall take reasonable steps to ensure that customers unable to travel shall not be denied the right to be heard.

c. The final step in a complaint hearing and review procedure shall be a filing for board resolution of the issues.

20.4(21) *Temporary service.* When the utility renders temporary service to a customer it may require that the customer bear all of the cost of installing and removing the service facilities in excess of any salvage realized.

20.4(22) *Change in type of service.* If a change in the type of service, such as from 25- to 60-cycle or from direct or alternating current, or a change in voltage to a customer's substation, is effected at the insistence of the utility and not solely by reason of increase in the customer's load or change in the character thereof, the utility shall share equitably in the cost of changing the equipment of the customer affected as determined by the board in the absence of agreement between utility and customer. In general, the customer should be protected against or reimbursed for the following losses and expenses to an appropriate degree:

a. Loss of value in electrical power utilization equipment.

b. Cost of changes in wiring, and

c. Cost of removing old and installing new utilization equipment.

20.4(23) *Limitation of service.* The utility shall have the option of adopting a policy for limiting the service of a residential customer for nonpayment of a bill or deposit, or for noncompliance with the terms of a payment agreement, as a measure to be taken prior to disconnection of the customer. Electric-heating residential customers shall not have limited service between November 1 and April 1. For purposes of this rule, "electric-heating" shall mean heating by means of a fixed-installation electric appliance which serves as the primary heat source.

A service limitation policy, if adopted by the utility, shall be set forth in the utility's tariff and shall specify some minimum time period for the service limiter to remain in place prior to the initiation of the disconnection procedure set forth in 20.4(15)*"h."* A service limitation policy, if adopted by the utility, shall be applied uniformly to all of the utility's residential customers, as specified above, to the extent that adaptation of service limiters to customer meters is feasible, and to the extent that customer meters are readily accessible to those installing the service limiters and to the customers. Any other exceptions to uniform application of this policy must be on the basis of rational, specific criteria set forth in the utility's tariff receiving prior approval by the board.

Notice of a pending service limitation shall be rendered, and electric service limited, as set forth in the tariff.

Upon installing a service limiter, the utility shall post the premises with a notice informing the occupant of the installation of the service limiter, its purpose, how it operates, and how it can be reset by the occupant.

The notice of pending service limitation required by these rules shall satisfy the requirements of subrule 20.4(15), substituting "service limitation" for "disconnection" or "refusal or disconnection of service" throughout the rule.

Service may be limited for nonpayment of bill or deposit, except as restricted by subrule 20.4(16), relating to insufficient reasons for denying service, provided that the utility has satisfied the requirements of 20.4(15)*"d,"* excluding the portion of subparagraph (4) "special circumstances" relating to same-day reconnection, and substituting "service limitation" for "disconnection" (and all other forms of that term) throughout that subrule. An installed service limiter shall be removed no later than the next working day after the residential customer has paid the delinquent bill or deposit in full or has entered into a reasonable payment agreement with the utility.

Service may be limited without the written 12-day notice for failure of the customer to comply with the terms of a payment agreement, provided that the requirements of 20.4(15)*"f"* have been satisfied, excluding the portion of subparagraph (2) relating to same-day reconnection, and substituting "service limitation" for "disconnection" (and all other forms of that term) throughout that subrule.

These rules are intended to implement Iowa Code sections 476.6, 476.8, 476.20 and 476.54.

199—20.5(476) Engineering practice.

20.5(1) *Requirement for good engineering practice.* The electric plant of the utility shall be constructed, installed, maintained and operated in accordance with accepted good engineering practice in the electric industry to assure, as far as reasonably possible, continuity of service, uniformity in the quality of service furnished, and the safety of persons and property.

20.5(2) *Standards incorporated by reference.* The utility shall use the applicable provisions in the publications listed below as standards of accepted good practice unless otherwise ordered by the board.

a. Iowa Electrical Safety Code, as defined in 199 IAC Chapter 25.

b. National Electrical Code, ANSI/NFPA 70-2008.

c. American National Standard Requirements for Instrument Transformers, ANSI/IEEE C57.13.1-2006; and C57.13.3-2006.

d. American National Standard for Electric Power Systems and Equipment Voltage Ratings (60 Hertz), ANSI C84.1-2006.

e. Grounding of Industrial and Commercial Power Systems, IEEE 142-2007.

f. IEEE Standard 1159-1995, IEEE Recommended Practice for Monitoring Electric Power Quality or any successor standard.

g. IEEE Standard 519-1992, IEEE Recommended Practices and Requirements for Harmonic Control in Electrical Power Systems or its successor standard.

h. At railroad crossings, 199 IAC 42.6(476), "Engineering standards for electric and communications lines."

20.5(3) *Adequacy of supply and reliability of service.* The generating capacity of the utility's plant, supplemented by the electric power regularly available from other sources, must be sufficiently large to meet all normal demands for service and provide a reasonable reserve for emergencies.

In appraising adequacy of supply the board will segregate electric utilities into two classes viz., those having high capacity transmission interconnections with other electrical utilities and those which lack such interconnection and are therefore completely dependent upon the firm generating capacity of the utility's own generating facilities.

a. In the case of utilities having interconnecting ties with other utilities, the board will, upon appraising adequacy of supply, take appropriate notice of the utility's recent past record, as of the date of appraisal, of any widespread service interruptions and any capacity shortages along with the consideration of the supply regularly available from other sources, the normal demands, and the required reserve for emergencies.

b. In the case of noninterconnected utilities the board will give attention to the maximum total coincident customer demand which could be satisfied without the use of the single element of plant equipment, the disability of which would produce the greatest reduction in total net plant productive

capacity and also give attention to the normal demands for service and to the reasonable reserve for emergencies.

20.5(4) *Electric transmission and distribution facilities.* Rescinded IAB 11/13/02, effective 12/18/02.

20.5(5) *Inspection of electric plant.* Each utility shall adopt a written program for inspection of its electric plant in order to determine the necessity for replacement and repair in compliance with board rule 199—25.3(476,478).

This rule is intended to implement Iowa Code section 476.8 and 478.18.

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—20.6(476) Metering.

20.6(1) *Inspection and testing program.* Each utility shall adopt a written program for the inspection and testing of its meters to determine the necessity for adjustment, replacement or repair. The frequency of inspection and methods of testing shall be based on the utility's experience, manufacturer's recommendations, and accepted good practice. The publications listed in 20.6(3) are representative of accepted good practice. Each utility shall maintain inspecting and testing records for each meter and associated device until three years after its retirement.

20.6(2) *Program content.* The written program shall, at minimum, address the following subject areas:

a. Classification of meters by capacity, type, and any other factor considered pertinent.

b. Checking of new meters for acceptable accuracy before being placed in service.

c. Testing of in-service meters, including any associated instruments or corrective devices, for accuracy, adjustments or repairs. This may be accomplished by periodic tests at specified intervals or on the basis of a statistical sampling plan, but shall include meters removed from service for any reason.

d. Periodic calibration or testing of devices or instruments used by the utility to test meters.

e. The limits of meter accuracy considered acceptable by the utility.

f. The nature of meter and meter test records which will be maintained by the utility.

20.6(3) *Accepted good practice.* The following publications are considered to be representative of accepted good practice in matters of metering and meter testing:

a. American National Standard Code for Electricity Metering, ANSI C12.1-2008.

b. and *c.* Rescinded IAB 5/23/07, effective 6/27/07.

20.6(4) *Meter adjustment.* All meters and associated metering devices shall, when tested, be adjusted as closely as practicable to the condition of zero error.

20.6(5) *Request tests.* Upon request by a customer, a utility shall test the meter servicing that customer. A test need not be made more frequently than once in 18 months.

A written report of the test results shall be mailed to the customer within ten days of the completed test and a record of each test shall be kept on file at the utility's office. The utility shall give the customer or a representative of the customer the opportunity to be present while the test is conducted.

If the test finds the meter is accurate within the limits accepted by the utility in its meter inspection and testing program, the utility may charge the customer $25 or the cost of conducting the test, whichever is less. The customer shall be advised of any potential charge before the meter is removed for testing.

20.6(6) *Referee tests.* Upon written request by a customer or utility, the board will conduct a referee test of a meter. A test need not be made more frequently than once in 18 months. The customer request shall be accompanied by a $30 deposit in the form of a check or money order made payable to the utility.

Within five days of receipt of the written request and payment, the board shall forward the deposit to the utility and notify the utility of the requirement for a test. The utility shall, within 30 days after notification of the request, schedule the date, time and place of the test with the board and customer. The meter shall not be removed or adjusted before the test. The utility shall furnish all testing equipment and facilities for the test. If the tested meter is found to be more than 2 percent fast or 2 percent slow, the deposit will be returned to the party requesting the test and billing adjustments shall be made as required in 20.4(14). The board shall issue its report within 15 days after the test is conducted, with a copy to the customer and the utility.

20.6(7) *Condition of meter.* No meter that is known to be mechanically or electrically defective, or to have incorrect constants, or that has not been tested and adjusted if necessary in accordance with these rules shall be installed or continued in service. The capacity of the meter and the index mechanism shall be consistent with the electricity requirements of the customer.
[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—20.7(476) Standards of quality of service.

20.7(1) Standard frequency. The standard frequency for alternating current distribution systems shall be 60 cycles per second. The frequency shall be maintained within limits which will permit the satisfactory operation of customer's clocks connected to the system.

20.7(2) Voltage limits retail. Each utility supplying electric service to ultimate customers shall provide service voltages in conformance with the standard at 20.5(2)*"d."*

20.7(3) Voltage balance. Where three-phase service is provided the utility shall exercise reasonable care to assure that the phase voltages are in balance. In no case shall the ratio of maximum voltage deviation from average to average voltage exceed .02.

20.7(4) Voltage limits, service for resale. The nominal voltage shall be as mutually agreed upon by the parties concerned. The allowable variation shall not exceed 7.5 percent above or below the agreed-upon nominal voltage without the express approval of the board.

20.7(5) Exceptions to voltage requirements. Voltage outside the limits specified will not be considered a violation when the variations:

a. Arise from the action of the elements.

b. Are infrequent fluctuations not exceeding five minutes, duration.

c. Arise from service interruptions.

d. Arise from temporary separation of parts of the system from the main system.

e. Are from causes beyond the control of the utility.

f. Do not exceed 10 percent above or below the standard nominal voltage, and service is at a distribution line or transmission line voltage with the retail customer providing voltage regulators.

20.7(6) Voltage surveys and records. Voltage measurements shall be made at the customer's entrance terminals. For single-phase service the measurement shall be made between the grounded conductor and the ungrounded conductors. For three-phase service the measurement shall be made between the phase wires.

20.7(7) Each utility shall make a sufficient number of voltage measurements, using recording voltmeters, in order to determine if voltages are in compliance with the requirements as stated in 20.7(2), 20.7(3), 20.7(4). All voltmeter records obtained under 20.7(7) shall be retained by the utility for at least two years and shall be available for inspection by the board's representatives. Notations on each chart shall indicate the following:

a. The location where the voltage was taken.

b. The time and date of the test.

c. The results of the comparison with a working standard indicating voltmeter.

20.7(8) Equipment for voltage measurements.

a. Secondary standard indicating voltmeter. Each utility shall have available at least one indicating voltmeter maintained with error no greater than 0.25 percent of full scale.

b. Working standard indicating voltmeters. Each utility shall have at least two indicating voltmeters maintained so as to have as-left errors of no greater than 1 percent of full scale.

c. Recording voltmeters. Each utility must have readily available at least two portable recording voltmeters with a rated accuracy of 1 percent of full scale.

20.7(9) Rescinded IAB 12/11/91, effective 1/15/92.

20.7(10) Extreme care must be exercised in the handling of standards and instruments to assure that their accuracy is not disturbed. Each standard shall be accompanied at all times by a certificate or calibration card, duly signed and dated, on which are recorded the corrections required to compensate for errors found at the customary test points at the time of the last previous test.

20.7(11) Planned interruptions shall be made at a time that will not cause unreasonable inconvenience to customers, and interruptions planned for longer than one hour shall be preceded by adequate notice to those who will be affected.

20.7(12) Power quality monitoring. Each utility shall investigate power quality complaints from its customers and determine if the cause of the problem is on the utility's systems. In addressing these problems, each utility shall implement to the extent reasonably practical the practices outlined in the standard given at 20.5(2)*"f."*

20.7(13) Harmonics. A harmonic is a sinusoidal component of the 60 cycles per second fundamental wave having a frequency that is an integral multiple of the fundamental frequency. When excessive harmonics problems arise, each electric utility shall investigate and take actions to rectify the problem. In addressing harmonics problems, the utility and the customer shall implement to the extent practicable and in conformance with prudent operation the practices outlined in the standard at 20.5(2)*"g."*

This rule is intended to implement Iowa Code sections 476.2 and 476.8.

199—20.8(476) Safety.

20.8(1) *Protective measures.* Each utility shall exercise reasonable care to reduce those hazards inherent in connection with its utility service and to which its employees, its customers, and the general public may be subjected and shall adopt and execute a safety program designed to protect the public and fitted to the size and type of its operations.

20.8(2) *Accident investigation and prevention.* The utility shall give reasonable assistance to the board in the investigation of the cause of accidents and in the determination of suitable means of preventing accidents.

20.8(3) *Reportable accidents.* Each utility shall maintain a summary of all reportable accidents, as defined in 199—25.5(476,478), arising from its operations.

20.8(4) *Grounding of secondary distribution system.* Unless otherwise specified by the board, each utility shall comply with, and shall encourage its customers to comply with, the applicable provisions of the acceptable standards listed in 20.5(2) for the grounding of secondary circuits and equipment.

Ground connections should be tested for resistance at the time of installation. The utility shall keep a record of all ground resistance measurements.

The utility shall establish a program of inspection so that all artificial grounds installed by it shall be inspected within reasonable periods of time.

199—20.9(476) Electric energy sliding scale or automatic adjustment. A rate-regulated utility's sliding scale or automatic adjustment of the unit charge for electric energy shall be an energy clause.

20.9(1) *Applicability.* A rate-regulated utility's sliding scale or automatic adjustment of electric utility energy rates shall recover from consumers only those costs which:

Are incurred in supplying energy;

Are beyond direct control of management;

Are subject to sudden important change in level;

Are an important factor in determining the total cost to serve; and

Are readily, precisely, and continuously segregated in the accounts of the utility.

20.9(2) *Energy clause for rate-regulated utility.* Prior to each billing cycle, a rate-regulated utility shall determine and file for board approval the adjustment amount to be charged for each energy unit consumed under rates set by the board. The filing shall include all journal entries, invoices (except invoices for fuel, freight, and transportation), worksheets, and detailed supporting data used to determine the amount of the adjustment. The estimated amount of fossil fuel should be detailed to reflect the amount of fuel, transportation, and other costs.

The journal entries should reflect the following breakdown for each type of fuel: actual cost of fuel, transportation, and other costs. Items identified as other costs should be described and their inclusion as fuel costs should be justified. The utility shall also file detailed supporting data:

1. To show the actual amount of sales of energy by month for which an adjustment was utilized, and

2. To support the energy cost adjustment balance utilized in the monthly energy adjustment clause filings.

a. The energy adjustment shall provide for change of the price per kilowatt hour consumed under rates set by the board based upon the formulas provided below. The calculation shall be:

$$E_0 = \frac{EC_0 + EC_1}{EQ_0 + EQ_1} + \frac{A_1}{EJ_0 + EJ_1} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

EC_0 is the estimated expense for energy in the month during which E_0 will be used.

EC_1 is the estimated expense for energy in the month prior to the month of EC_0.

EQ_0 is the estimated electric energy to be consumed or delivered and entered in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered into account 447 and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts during the month in which E_0 will be used.

EQ_1 is the estimated electric energy to be consumed or delivered and entered in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered in account 447 and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts during the month prior to EQ_0.

EJ_0 is the estimated electric energy to be consumed under rates set by the board in the month during which the energy adjustment charge (E_0) will be used in bill calculations.

EJ_1 is the estimated electric energy to be consumed under rates set by the board in the month prior to the month of EJ_0.

A_1 is the beginning of the month energy cost adjustment account balance for the month of estimated consumption EJ_1. This would be the most recent month's balance available from actual accounting data.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

b. The estimated energy cost ($EC_0 + EC_1$) shall be the estimated cost associated with EQ_0 and EQ_1 determined as the cost of:

(1) Fossil and nuclear fuel consumed in the utility's own plants and the utility's share of fossil and nuclear fuel consumed in jointly owned or leased plants. Fossil fuel shall include natural gas used for electric generation and the cost of fossil fuel transferred from account 151 to account 501 or 547 of the Uniform System of Accounts for Electric Utilities. Nuclear fuel shall be that shown in account 518 of the Uniform System of Accounts except that if account 518 contains any expense for fossil fuel which has already been included in the cost of fossil fuel, it shall be deducted from the account. (Paragraph C of account 518 includes the cost of other fuels used for ancillary steam facilities.)

(2) The cost of steam purchased, or transferred from another department of the utility or from others under a joint facility operating agreement, for use in prime movers producing electric energy (accounts 503 and 521).

(3) A deduction shall be made of the expenses of producing steam chargeable to others, to other utility departments under a joint operating agreement, or to other electric accounts outside the steam generation group of accounts (accounts 504 and 522).

(4) The cost of water used for hydraulic power generation. Water cost shall be limited to items of account 536 of the Uniform System of Accounts. For pumped storage projects the energy cost of pumping is included. Pumping energy cost shall be determined from the applicable costs of subparagraphs of paragraph 20.9(2)*"b."*

(5) The energy costs paid for energy purchased under arrangements or contracts for firm power, operational control energy, outage energy, participation power, peaking power, and economy energy, as

entered into account 555 of the Uniform System of Accounts, less the energy revenues to be recovered from corresponding sales, as entered in account 447 of the Uniform System of Accounts.

(6) Purchases from AEP facilities under rule 199—15.11(476).

(7) The weighted average costs of inventoried allowances used in generating electricity.

(8) The gains and losses, as described in subrule 20.17(9), from allowance transactions occurring during the month. Allowance transactions shall include vintage trades and emission for emission trades.

(9) Eligible costs or credits associated with the utility's annual reconciliation of its alternate energy purchase program under 199—paragraph 15.17(4)*"b."*

c. The energy cost adjustment account balance (A) shall be the cumulative balance of any excess or deficiency which arises out of the difference between board recognized energy cost recovery and the amount recovered through application of energy charges to consumption under rates set by the board. Each monthly entry (D) into the energy cost adjustment account shall be the dollar amount determined from solution of the following equation (with proper adjustment for those deliveries at high voltage which for billing purposes recognized the lower losses associated with the high voltage deliveries).

$$D = \left[C_2 \times \frac{J_2}{Q_2} \right] - \left[J_2 \times (E_2 + B) \right]$$

C_2 is the actual expense for energy, calculated as set forth in 20.9(2)*"b,"* in the month prior to EJ_1 of 20.9(2)*"a."*

J_2 is the actual energy consumed in the prior month under rates set by the board and recorded in accounts 440, 442 and 444-6 of the Uniform System of Accounts.

Q_2 is the actual total energy consumed or delivered in the prior month and recorded in accounts 440, 442, 444-7, excluding energy from distinct interchange deliveries entered in account 447, and including intrautility energy service as included in accounts 448 and 929 of the Uniform System of Accounts.

E_2 is the energy adjustment charge used for billing in the prior month.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

d. Reserve account for nuclear generation. A rate-regulated utility owning nuclear generation or purchasing energy under a participation power agreement on nuclear generation may establish a reserve account. The reserve account will spread the higher cost of energy used to replace that normally received from nuclear sources. A surcharge would be added to each kilowatt hour from the nuclear source. The surcharges collected are credited to the reserve account. During an outage or reduced level of operation, replacement energy cost would be offset through debit to the reserve account. The debit would be based upon the cost differential between replacement energy cost and the average cost (including the surcharge) of energy from the nuclear capacity. A reserve account shall have credit and debit limitations equal in dollar amounts to the total cost differential for replacement energy during a normal refueling outage.

e. A rate-regulated utility desiring to collect expensed allowance costs and the gains and losses from allowance transactions through the energy adjustment must file with the board monthly reports including:

(1) The number and weighted average unit cost of allowances used during the month to offset emissions from the utility's affected units;

(2) The number and unit price of allowances purchased during the month;

(3) The number and unit price of allowances sold during the month;

(4) The weighted average unit cost of allowances remaining in inventory;

(5) The dollar amount of any gain from an allowance sale occurring during the month;

(6) The dollar amount of any loss from an allowance sale occurring during the month; and

(7) Documentation of any gain or loss from an allowance sale occurring during the month.

f. A rate-regulated utility which proposes a new sliding scale or automatic adjustment clause of electric utility energy rates shall conform such clause with the rules.

20.9(3) *Optional energy clause for a rate-regulated utility which does not own generation.* A rate-regulated utility which does not own generation may adopt the energy adjustment clause of this subrule in lieu of that set forth in subrule 20.9(2). Prior to each billing cycle it shall determine and

file for board approval the adjustment amount to be charged for each energy unit consumed under rates set by the board. The filing shall include all journal entries, invoices (except invoices for fuel, freight, and transportation), worksheets, and detailed supporting data used to determine the amount of the adjustment. The estimated amount of fossil fuel should be detailed to reflect the amount of fuel, transportation, and other costs.

The journal entries should reflect the following breakdown for each type of fuel: actual cost of fuel, transportation, and other costs. Items identified as other costs should be described and their inclusion as fuel costs should be justified. The utility shall also file detailed supporting data:

1. To show the actual amount of sales of energy by month for which an adjustment was utilized, and
2. To support the energy cost adjustment balance utilized in the monthly energy adjustment clause filings.

a. The energy adjustment charge shall provide for change of the price per kilowatt-hour consumed to equal the average cost per kilowatt hour delivered by the utility's system. The calculation shall be:

$$E_0 = \frac{C_2 + C_3 + C_4}{Q_2 + Q_3 + Q_4} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

C_2, C_3 and C_4 are the charges by the wholesale suppliers as recorded in account 555 offset by energy revenues from distinct interchange deliveries entered in account 447 of the Uniform System of Accounts for the first three of the four months prior to the month in which E_0 will be used.

Q_2, Q_3 and Q_4 are the total electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 during each of the months in which the expenses C_2, C_3 and C_4 were incurred.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

b. A utility purchasing its total electric energy requirements may establish an energy cost adjustment account for which the cumulative balance is the excess or deficiency arising from the difference between commission-recognized energy cost recovery and the amount recovered through application of energy charges on jurisdictional consumption.

For a utility electing to use an energy cost adjustment account the calculation shall be:

$$E_0 = \frac{C_2 + C_3 + C_4}{Q_2 + Q_3 + Q_4} + \frac{A_2}{J_2 + J_3 + J_4} - B$$

E_0 is the energy adjustment charge to be used in the next customer billing cycle rounded on a consistent basis to either the nearest 0.01¢/kWh or 0.001¢/kWh. For deliveries at voltages higher than secondary line voltages, appropriate factors should be applied to the adjustment charge to recognize the lower losses associated with these deliveries.

C_2, C_3 and C_4 are the charges by the wholesale suppliers as recorded in account 555 offset by energy revenues from distinct interchange deliveries entered in account 447 of the Uniform System of Accounts for the first three of the four months prior to the month in which E_0 will be used.

Q_2, Q_3 and Q_4 are the total electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 during each of the months in which the expenses C_2, C_3 and C_4 were incurred.

A_2 is the end of the month energy cost adjustment account balance for the month of consumption J_2. This would be the most recent month's balance available from actual accounting data.

J_2, J_3 and J_4 are electric energy consumed under rates set by the board in the months corresponding to C_2, C_3 and C_4.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

c. The end of the month energy cost adjustment account balance (A) shall be the cumulative balance of any excess or deficiency which arises out of the difference between board recognized energy cost recovery and the amount recovered through application of energy charges to consumption under rates set by the board.

Each monthly entry (D) into the energy cost adjustment account shall be the dollar amount determined from solution of the following equation (with proper adjustment for those deliveries at high voltage which for billing purposes recognized the lower losses associated with the high voltage deliveries).

$$D = \left[C_2 \times \frac{J_2}{Q_2} \right] - \left[J_2 \times (E_2 + B) \right]$$

C_2 is the prior month charges by the wholesale suppliers as recorded in account 555 of the Uniform System of Accounts offset by energy revenues from distinct interchange deliveries entered in account 447.

J_2 is the electric energy consumed under jurisdictional rates in the prior month.

Q_2 is the electric energy delivered by the utility system, excluding energy from distinct interchange deliveries entered in account 447 in the prior month.

E_2 is the energy adjustment charge used for billing in the prior month.

B is the amount of the electric energy cost included in the base rates of a utility's rate schedules.

d. A utility with special conditions may petition the board for a waiver which would recognize its unique circumstances.

e. A utility which does not own generation and proposes a new sliding scale or automatic adjustment clause of electric utility rates shall conform such clause with the rules.

20.9(4) *Annual review of energy clause.* On or before each May 1, the board will notify each utility as to the two months of the previous calendar year for which fuel, freight, and transportation invoices will be required. Two copies of these invoices shall be filed with the board no later than the subsequent November 1.

This rule is intended to implement Iowa Code section 476.6(11).

199—20.10(476) Ratemaking standards.

20.10(1) *Coverage.* Standards for ratemaking shall apply to all rate-regulated utilities in the state of Iowa. The board may, by rule or by order in specific cases, exempt a utility or class of utilities from any or all ratemaking standards. The standards are recommended to all service-regulated utilities in this jurisdiction.

20.10(2) *Cost of service.* Rates charged by an electric utility for providing electric service to each class of electric consumers shall be designed, to the maximum extent practicable, to reasonably reflect the costs of providing electric service to the class. The methods used to determine class costs of service shall to the maximum extent practical permit identification of differences in cost-incurrence, for each class of electric consumers, attributable to daily and seasonal time of use of service, and permit identification of differences in cost-incurrence attributable to differences in demand, energy, and customer components of cost.

The design of rates should reasonably approximate a pricing methodology for any individual utility that would reflect the price system that would exist in a competitive market environment. For purposes of determining revenue requirements among customer classes, embedded costs shall be preferred. For purposes of determining rate designs within customer classes, long-run marginal cost approaches are preferred although embedded cost approaches may be considered reasonable.

Nothing in this rule shall authorize or require the recovery by an electric utility of revenues in excess of, or less than, the amount of revenues otherwise determined to be lawful by the board.

Guidelines for use in evaluating the acceptability of methods of class cost of service estimation include, but are not limited to, the following:

a. All usage of customer, demand, and energy components of service shall be considered new usage.

b. Customer classes shall be established on the primary basis of reasonably similar usage patterns within classes, even if this requires disaggregation or recombination of traditional customer classes.

c. Generating capacity estimates or allocations among and within classes shall recognize that utility systems are designed to serve both peak and off-peak demand, and shall attribute costs based upon both peak period demand and the contribution of off-peak period demand in determining generation mix. Generating capacity estimates and allocations among and within classes shall be based on load data for each class as described in 199—subrule 35.9(2).

d. Transmission and distribution capacity estimates or allocations among and within classes shall be demand-related based upon system usage patterns, and the load imposed by a class on the transmission or distribution capacity in question.

e. Customer cost component estimates or allocations shall include only costs of the distribution system from and including transformers, meters and associated customer service expenses.

f. Methods of cost estimates or allocations among customer classes shall recognize the differences in voltage levels and other service characteristics, and line losses among customer classes.

g. Methods of class cost of service determination which are consistent with zero customer, demand, or energy component costs or major categories of these, such as generation, transmission or distribution, shall be considered unacceptable methods.

h. Long-run marginal cost methods of class cost of service determination shall clearly reflect changes in total costs to the utility with respect to changes in the outputs of customer, demand, or energy components of electric services.

i. The use of an inverse elasticity approach to adjust long-run marginal cost-based rates to the revenue requirement shall be unacceptable. Other approaches will be considered on a case-by-case basis.

20.10(3) *Declining block rates.* The energy-related cost component of a rate, or the amount attributable to the energy-related cost component of a rate, charged by an electric utility for providing electric service during any period to any class of electric consumers, shall not decrease as kilowatt-hour consumption by such class increases during the period except to the extent that the utility demonstrates that the energy costs of providing electric service to such class decrease as consumption increases during the period.

20.10(4) *Time-of-day rates.* The rates charged by any electric utility for providing electric service to each class of electric consumers shall be on a time-of-day basis which reflects the cost of providing electric service to that class of electric consumers at different times of the day unless such rates are not cost-effective with respect to the class. These rates are cost-effective with respect to a class if the long-run benefits of the rate to the electric utility and its electric consumers in the class concerned are likely to exceed the metering costs and other costs associated with the use of the rates. Cost-based time-of-day rates shall be offered on an optional basis to electric consumers who do not otherwise qualify for the rates if consumers agree to pay the additional metering costs and other costs associated with the use of the rates.

20.10(5) *Seasonal rates.* The rates charged by an electric utility for providing electric service to each class of electric consumers may be on a seasonal basis which reflects the costs of providing service to the class of consumers at different seasons of the year to the extent that costs vary seasonally for the utility, if the board determines that seasonal rates are appropriate in an individual case.

20.10(6) *Interruptible rates.* Each electric utility shall offer each industrial and commercial electric consumer an interruptible rate which reflects the cost of providing interruptible service to the class of which the consumer is a member.

20.10(7) *Load management techniques.* Rescinded IAB 11/12/03, effective 12/17/03.

20.10(8) *Other energy conservation strategies.* Rescinded IAB 11/12/03, effective 12/17/03.

20.10(9) *Pilot projects.* Rescinded IAB 11/12/03, effective 12/17/03.

199—20.11(476) Customer notification of peaks in electric energy demand. Each electric utility shall inform its customers of the significance of reductions in consumption of electricity during hours of peak demand.

20.11(1) *Annual notice.* Each electric utility shall provide its customers, on an annual basis, with a written notice explaining how growth in demand affects a utility's investment costs and why reduction of customer usage during periods of peak demand may help delay or reduce the amount of future rate increases. The notice shall be delivered to its customers between May 1 and June 15 of each year if peak demand is likely to occur during the months of June through September. If peak demand usually occurs during the months of October through February, the notice shall be delivered to its customers between August 1 and September 15.

20.11(2) *Notification plan.* Each investor-owned utility shall have on file with the board a plan to notify its customers of an approaching peak demand on the day when peak demand is likely to occur.

a. The plan shall include the following:

(1) A provision for a general notice to be given customers prior to the time when peak demand is likely to occur as prescribed in 20.11(2)*"b"* and an explanation of when and how notice of an approaching peak in electric demand will be given to customers.

(2) A provision for direct notice to be given customers whose load reduction will have a significant impact on the utility's peak. The utility shall provide for such notice to be given prior to the time when peak demand is likely to occur, as prescribed in 20.11(2)*"b,"* and shall explain the criteria used to identify customers to whom notice will be given and when and how notice will be given.

(3) A statement showing the total costs, with each component thereof itemized, projected to be associated with implementing the plan. Notice should be provided in the most efficient manner available. The board may reject a plan which includes excessive costs or which specifies an ineffective method of customer notification and may direct development of a new plan.

(4) The text of the general and direct message to be given in the general notice to customers. The message shall, at a minimum, include the name of the utility or utilities providing the notice, an explanation that conditions exist which indicate a peak in demand is approaching, and a statement that reduction in usage of electricity during the period of peak demand will ease the burden placed on the utility's system by growth in peak demand and may help delay or reduce the amount of future rate increases.

(5) A designation of the U.S. weather station(s), situated within the utility's service territory, whose temperature readings and predictions will be used by the utility in applying the standard in 20.11(2)*"b."*

(6) A provision for joint delivery, by two or more utilities, of the general notice to customers in regions of the state where U.S. weather station(s) predict conditions specified in 20.11(2)*"b"* will exist on the same day.

b. For purposes of this rule, peak demand is likely to occur on a nonholiday weekday between June 15 and September 15 when the following conditions exist:

(1) The utility's designated weather station predicts the temperature will rise above 95° Fahrenheit (35° Celsius), and the designated weather station officially recorded a temperature above 95° Fahrenheit (35° Celsius) on the previous day, or

(2) The utility's designated weather station predicts the temperature will rise to above 90° Fahrenheit (33° Celsius) on a day following at least two consecutive days of temperatures above 95° Fahrenheit (35° Celsius), as officially recorded by the designated weather station, but

(3) If a utility can demonstrate it would have been required to provide between June 15 and September 15 a peak alert notice to customers, because of the existence of the conditions set forth in 20.11(2)*"b"*(1) or 20.11(2)*"b"*(2), on more than six days in any one of the preceding ten years, the utility may substitute a 97° Fahrenheit (36° Celsius) standard in lieu of the 95° Fahrenheit (35° Celsius) standard in the subrule.

20.11(3) *Implementation of notification plan.* The utility shall implement the approved plan on each day of the year when peak demand is likely to occur, as prescribed by 20.11(2)*"b."*

20.11(4) *Permissive notices.* The standard for implementing peak alert notification in subrule 20.11(2) is a minimum standard and does not prohibit a utility or association of utilities from issuing a notice requesting customers to reduce usage at any other time.

20.11(5) *Annual report.* Each electric utility required by subrule 20.11(2) to file a plan for customer notification shall file, on or before April 1 of each year, a report stating the number of notices given its customers, the dates when notices were issued, the annual cost of providing both general and direct notice to customers and measures of kilowatt hour demand at the time when notice was given and at hourly intervals thereafter until kilowatt hour demand decreases to the level at which it was measured when the notice was issued. The annual report shall also include a statement of any problems experienced by the utility in providing customer notification of a peak demand and a proposal to modify the plan, if necessary, to make customer notification more effective. Modifications must be approved by the board before they are implemented.

199—20.12(476) New structure energy conservation standards. Rescinded IAB 11/12/03, effective 12/17/03.

199—20.13(476) Periodic electric energy supply and cost review [476.6(16)].

20.13(1) *Procurement plan.* The board shall periodically conduct a contested case proceeding for the purpose of evaluating the reasonableness and prudence of a rate-regulated public utility's electric fuel procurement and contracting practices. By January 31 each year the board will notify a rate-regulated utility if the utility will be required to file an electric fuel procurement plan. In the years in which it does not conduct a contested case proceeding, the board may require a utility to file certain information for the board's review. In years in which a full proceeding is conducted, a rate-regulated utility providing electric service in Iowa shall prepare and file with the board on or before May 15 of each required filing year a complete electric fuel procurement plan for an annual period commencing June 1 or, in the alternative, for the annual period used by the utility in preparing its own fuel procurement plan. A utility's procurement plan shall be organized to include information as follows:

a. Index. The plan shall include an index of all documents and information required to be filed in the plan, and the identification of the board files in which the documents incorporated by reference are located.

b. Purchase contracts and arrangements. A utility's procurement plan shall include detailed summaries of the following types of contracts and agreements executed since the last procurement review:

(1) All contracts and fuel supply arrangements for obtaining fuel for use by any unit in generation;

(2) All contracts and arrangements for transporting fuel from point of production to the site where placed in inventory, including any unit generating electricity for the utility;

(3) All contracts and arrangements for purchasing or selling allowances;

(4) Purchased power contracts or arrangements, including sale-of-capacity contracts, involving over 25 MW of capacity;

(5) Pool interchange agreements;

(6) Multiutility transmission line interchange agreements; and

(7) Interchange agreements between investor-owned utilities, generation and transmission cooperatives, or both, not required to be filed above, which were entered into or in effect since the last filing, and all such contracts or arrangements which will be entered into or exercised by the utility during the prospective 12-month period.

All procurement plans filed by a utility shall include all of the types of contracts and arrangements listed in subparagraphs (1) and (2) of this paragraph which will be entered into or exercised by the utility during the prospective 12-month period. In addition, the utility shall file an updated list of contracts that are or will become subject to renegotiation, extension, or termination within five years. The utility shall also update any price adjustment affecting any of the filed contracts or arrangements.

c. Other contract offers. The procurement plan shall include a list and description of those types of contracts and arrangements listed in paragraph 20.13(1)*"b"* offered to the utility since the last filing

into which the utility did not enter. In addition, the procurement plan shall include a list of those types of contracts and arrangements listed in paragraph 20.13(1)*"b"* which were offered to the utility for the prospective 12-month period and into which the utility did not enter.

d. Studies or investigation reports. The procurement plans shall include all studies or investigation reports which have been considered by the utility in deciding whether to enter into any of those types of contracts or arrangements listed in paragraphs 20.13(1)*"b"* and *"c"* which will be exercised or entered into during the prospective 12-month period.

e. Price hedge justification. The procurement plan shall justify purchasing allowance futures contracts as a hedge against future price changes in the market rather than for speculation.

f. Actual and projected costs. The procurement plan shall include an accounting of the actual costs incurred in the purchase and transportation of fuel and the purchase of allowances for use in generating electricity associated with each contract or arrangement filed in accordance with paragraph 20.13(1)*"b"* for the previous 12-month period.

The procurement plan also shall include an accounting of all costs projected to be incurred by the utility in the purchase and transportation of fuel and the purchase of allowances for use in generating electricity associated with each contract or arrangement filed in accordance with paragraph 20.13(1)*"b"* in the prospective 12-month period.

If applicable, the reporting of transportation costs in the procurement plan shall include all known liabilities, including all unit train costs.

g. Costs directly related to the purchase of fuel. The utility shall provide a list and description of all other costs directly related to the purchase of fuels for use in generating electricity not required to be reported by paragraph *"f."*

h. Compliance plans. Each utility shall file its emissions compliance plan as submitted to the EPA. Revisions to the compliance plan shall be filed with each subsequent procurement plan.

i. Evidence submitted. Each utility shall submit all factual evidence and written argument in support of its evaluation of the reasonableness and prudence of the utility's procurement practice decisions in the manner described in its procurement plan. The utility shall file data sufficient to forecast fuel consumption at each generating unit or power plant for the prospective 12-month period. The board may require the submission of machine-readable data for selected computer codes or models.

j. Additional information. Each utility shall file additional information as ordered by the board.

20.13(2) *Periodic review proceeding.* The board shall periodically conduct a proceeding to evaluate the reasonableness and prudence of a rate-regulated utility's procurement practices. The prudence review of allowance transactions and accompanying compliance plans shall be determined on information available at the time the options or plans were developed.

a. On or before May 15 of a required filing year, each utility shall file prepared direct testimony and exhibits in support of its fuel procurement decisions and its fuel requirement forecast. This filing shall be in conjunction with the filing of the plans. The burden shall be on the utility to prove it is taking all reasonable actions to minimize its purchased fuel costs.

b. The board shall disallow any purchased fuel costs in excess of costs incurred under responsible and prudent policies and practices.

199—20.14(476) Flexible rates.

20.14(1) *Purpose.* This subrule is intended to allow electric utility companies to offer, at their option, incentive or discount rates to their customers.

20.14(2) *General criteria.*

a. Electric utility companies may offer discounts to individual customers, to selected groups of customers, or to an entire class of customers. However, discounted rates must be offered to all directly competing customers in the same service territory. Customers are direct competitors if they make the same end product (or offer the same service) for the same general group of customers. Customers that only produce component parts of the same end product are not directly competing customers.

b. In deciding whether to offer a specific discount, the utility shall evaluate the individual customer's, group's, or class's situation and perform a cost-benefit analysis before offering the discount.

c. Any discount offered should be such as to significantly affect the customer's or customers' decision to stay on the system or to increase consumption.

d. The consequences of offering the discount should be beneficial to all customers and to the utility. Other customers should not be at risk of loss as a result of these discounts; in addition, the offering of discounts shall in no way lead to subsidization of the discounted rates by other customers in the same or different classes.

20.14(3) *Tariff requirements.* If a company elects to offer flexible rates, the utility shall file for review and approval tariff sheets specifying the general conditions for offering discounted rates. The tariff sheets shall include, at a minimum, the following criteria:

a. The cost-benefit analysis must demonstrate that offering the discount will be more beneficial than not offering the discount.

b. The ceiling for all discounted rates shall be the approved rate on file for the customer's rate class.

c. The floor for the discount rate shall be equal the energy costs and customer costs of serving the specific customer.

d. No discount shall be offered for a period longer than five years, unless the board determines upon good cause shown that a longer period is warranted.

e. Discounts should not be offered if they will encourage deterioration in the load characteristics of the customer receiving the discount.

20.14(4) *Reporting requirements.* Each rate-regulated electric utility electing to offer flexible rates shall file annual reports with the board within 30 days of the end of each 12 months. Reports shall include the following information:

a. Section 1 of the report concerns discounts initiated in the last 12 months. For all discounts initiated in the last 12 months, the report shall include:

(1) The identity of the new customers (by account number, if necessary);

(2) The value of the discount offered;

(3) The cost-benefit analysis results;

(4) The end-use cost of alternate fuels or energy supplies available to the customer, if relevant;

(5) The energy and demand components by month of the amount of electricity sold to the customer in the preceding 12 months.

b. Section 2 of the report relates to overall program evaluation. Amount of electricity refers to both energy and demand components when the customer is billed for both elements. For all discounts currently being offered, the report shall include:

(1) The identity of each customer (by account number, if necessary);

(2) The amount of electricity sold in the last 12 months to each customer at discounted rates, by month;

(3) The amount of electricity sold to each customer in the same 12 months of the preceding year, by month;

(4) The dollar value of the discount in the last 12 months to each customer, by month; and

(5) The dollar value of sales to each customer for each of the previous 12 months.

c. Section 3 of the report concerns discounts denied or discounts terminated. For all customers specifically evaluated and denied or having a discount terminated in the last 12 months, the report shall include:

(1) Customer identification (by account number, if necessary);

(2) The amount of electricity sold in the last 12 months to each customer, by month;

(3) The amount of electricity sold to each customer in the same 12 months of the preceding year, by month; and

(4) The dollar value of sales to each customer for each of the past 12 months.

d. No monthly report is required if the utility had no customers receiving a discount during the relevant period and had no customers which were evaluated for the discount and rejected during the relevant period.

20.14(5) *Rate case treatment.* In a rate case, 50 percent of any identifiable increase in net revenues will be used to reduce rates for all customers; the remaining 50 percent of the identifiable increase in net revenues may be kept by the utility. If there is a decrease in revenues due to the discount, the utility's test year revenues will be adjusted to remove the effects of the discount by assuming that all sales were made at full tariffed rates for the customer class. Determining the actual amount will be a factual determination to be made in the rate case.

199—20.15(476) Customer contribution fund.

20.15(1) *Applicability and purpose.* This rule applies to each electric public utility, as defined in Iowa Code sections 476.1, 476.1A, and 476.1B. Each utility shall maintain a program plan to assist the utility's low-income customers with weatherization and to supplement assistance received under the federal low-income home energy assistance program for the payment of winter heating bills.

20.15(2) *Program plan.* Each utility shall have on file with the board a detailed description of its current program plan. At a minimum, the plan shall include the following information:

a. A list of the members of the governing board, council, or committee established to determine the appropriate distribution of the funds collected. The list shall include the organization each member represents;

b. A sample of the customer notification with a description of the method and frequency of its distribution;

c. A sample of the authorization form provided to customers;

d. The date of implementation.

Program plans for new customer contribution funds shall be rejected if not in compliance with this rule.

20.15(3) *Notification.* Each utility shall notify all customers of the fund at least twice a year. The method of notice which will ensure the most comprehensive notification to the utility's customers shall be employed. Upon commencement of service and at least once a year, the notice shall be mailed or personally delivered to all customers. The other required notice may be published in a local newspaper(s) of general circulation within the utility's service territory. A utility serving fewer than 6000 customers may publish their semiannual notices locally in a free newspaper, utility newsletter or shopper's guide instead of a newspaper. At a minimum the notice shall include:

a. A description of the availability and the purpose of the fund;

b. A customer authorization form. This form shall include a monthly billing option and any other methods of contribution.

20.15(4) *Methods of contribution.* The utility shall provide for contributions as monthly pledges, as well as one-time or periodic contributions. Each utility may allow persons or organizations to contribute matching funds.

20.15(5) *Annual report.* On or before September 30 of each year, each utility shall file with the board a report of all the customer contribution fund activity for the previous fiscal year beginning July 1 and ending June 30. The report shall be in a form provided by the board and shall contain an accounting of the total revenues collected and all distributions of the fund. The utility shall report all utility expenses directly related to the customer contribution fund.

20.15(6) *Binding effect.* A pledge by a customer or other party shall not be construed to be a binding contract between the utility and the pledgor. The pledge amount shall not be subject to delayed payment charges by the utility.

199—20.16(476) Exterior flood lighting. Rescinded IAB 11/12/03, effective 12/17/03.

199—20.17(476) Ratemaking treatment of emission allowances.

20.17(1) *Applicability and purpose.* This rule applies to all rate-regulated utilities providing electric service in Iowa. Under Title IV of the Clean Air Act Amendments of 1990, each electric utility is required to hold sufficient emission allowances to offset emissions at all affected and new units. The acquisition and disposition of emission allowances will be treated for ratemaking purposes as defined in this rule.

20.17(2) *Definitions.* The following words and terms, when used in this rule, shall have the meaning indicated below:

"Allowance futures contract" is an agreement between a futures exchange clearinghouse and a buyer or seller to buy or sell an allowance on a specified future date at a specified price.

"Allowance option contract" is an agreement between a buyer and seller whereby the buyer has the option to transfer an allowance(s) at a specified date at a specified price. The seller of a call or put option will receive a premium for taking on the associated risk.

"Auction allowances" are allowances acquired or sold through EPA's annual allowance auction.

"Boot" means something acquired or forfeited to equalize a trade.

"Direct sale allowances" are allowances purchased from the EPA in its annual direct sale.

"Emission for emission trade" is an exchange of one type of emission for another type of emission. For example, the exchange of SO_2 emission allowances for NO_x emission allowances.

"Fair market value" is the amount at which an allowance could reasonably be sold in a transaction between a willing buyer and a willing seller other than in a forced or liquidation sale.

"Historical cost" is the amount of cash or its equivalent paid to acquire an asset, including any direct acquisition expenses. Any commissions paid to brokers shall be considered a direct acquisition expense.

"Original cost" is the historical cost of an asset to the person first devoting the asset to public service.

"Statutory allowances" are allowances allocated by the EPA at no cost to affected units under the Acid Rain Program either through annual allocations as a matter of statutory right and those for which a utility may qualify by using certain compliance options or effective use of conservation and renewables.

"Vintage trade" is an exchange of one vintage of allowances for another vintage of allowances with the difference in value between vintages being cash or additional allowances.

20.17(3) *Valuing allowances for ratemaking purposes.*

a. Statutory allowances. Valued at zero cost to electric utility.

b. Direct sale allowances. Valued at historical cost.

c. Auction allowances. Valued at historical cost.

d. Purchased allowances. Valued at historical cost.

20.17(4) *Valuing allowance inventory accounts.* Allowance inventory accounts shall be valued at the weighted average cost of all allowances eligible for use during that year.

20.17(5) *Valuing allowances acquired as part of a package.* Allowances acquired as part of a package with equipment, fuel, or electricity shall be valued at their fair market value at the time the allowances were acquired.

20.17(6) *Valuing allowances acquired through exchanges.*

a. Exchanges without boot. Electric utilities shall value allowances received in exchanges based on the recorded inventory value of the allowances relinquished.

b. Exchanges with boot. Electric utilities shall value allowances as the sum of the inventory cost of the allowances given up and the monetary consideration paid in boot for the newly acquired allowances. In determining the historical cost of allowances received, a gain (or loss) shall be recorded to the extent that the amount of boot received exceeds a proportionate share of the recorded weighted average inventory cost of the allowance surrendered. The proportionate share shall be based upon the ratio of the monetary consideration received (i.e., boot) to the total consideration received (monetary consideration plus the fair market value of the allowances received). The historical cost of the allowances received shall be equal to the amount derived by subtracting the difference between the boot received and the gain from the old inventory cost.

20.17(7) *Valuing allowances transferred among affiliates.*

a. Allowances transferred from a utility to a parent or unregulated subsidiary. Allowances shall be transferred at the higher of historical cost or fair market value.

b. Allowances transferred from an unregulated subsidiary or parent to a utility. Allowances shall be transferred at the lesser of original cost or fair market value.

c. Allowances transferred from a utility to an affiliated utility. Allowances shall be transferred at fair market value.

20.17(8) *Expense recognition and recovery of allowance costs.*

a. Expense recognition. Electric utilities shall charge allowances (including fractional amounts) to expense in the month in which related emissions occur.

b. Expense recovery. The expense associated with allowances used for compliance shall be passed through the energy adjustment as specified in rule 20.9(476). The expense associated with allowances used for compliance shall include expenses associated with vintage trades and emission for emission trades.

c. Allowance inventory shortage. If a utility emits more emissions in a month than it has allowances in inventory, the utility shall pass the estimated cost of acquiring the needed allowances through the energy adjustment. When the needed allowances are acquired, any difference between the estimated and actual cost of the allowances shall be passed through the energy adjustment as specified in rule 20.9(476).

20.17(9) *Gains/losses from allowance transactions.* The gains and losses, including net gains and losses, from allowance transactions shall be passed through the energy adjustment as specified in rule 20.9(476). Allowance transactions shall include vintage trades and emission for emission trades.

20.17(10) *Allowance futures or option contracts.*

a. Price hedging. Electric utilities shall defer the costs or benefits from hedging transactions and include such amounts in inventory values when the related allowances are acquired, sold, or otherwise disposed of. Where the costs or benefits of hedging transactions are not identifiable with specific allowances, the amounts shall be included in inventory values when the futures contract is closed.

b. Speculation. Allowance transactions entered into for the purpose of speculation shall not affect allowance inventory pricing.

20.17(11) *Working capital reserve of allowances.* A working capital reserve of allowances shall be established in each utility's rate case proceeding based on the probability of forced outages, fuel quality variability, variability in load growth, nuclear exposure, the price and availability of allowances on the national market, and any other factors that the board deems appropriate. The working capital reserve will earn at the utility's authorized rate of return.

20.17(12) *Allowances banked for future use.* Allowances banked for future use shall be considered plant held for future use in utility rate proceedings if a definitive plan and schedule for use of the allowances is deemed adequate by the board.

20.17(13) *Prudence of allowance transactions.* The prudence of allowance transactions shall be determined by the board in the periodic electric energy supply and cost review. The prudency review of allowance transactions and accompanying compliance plans shall be based on information available at the time the options or plans were developed. Costs recovered from ratepayers through the energy adjustment that are deemed imprudent by the board shall be refunded with interest to ratepayers through the energy adjustment as specified in rule 20.9(476).

199—20.18(476,478) Service reliability requirements for electric utilities.

20.18(1) *Applicability.* Rule 20.18(476,478) is applicable to investor-owned electric utilities and electric cooperative corporations and associations operating within the state of Iowa subject to Iowa Code chapter 476 and to the construction, operation, and maintenance of electric transmission lines by electric utilities as defined in subrule 20.18(4) to the extent provided in Iowa Code chapter 478.

20.18(2) *Purpose and scope.* Reliable electric service is of high importance to the health, safety, and welfare of the citizens of Iowa. The purpose of rule 20.18(476,478) is to establish requirements for assessing the reliability of the transmission and distribution systems and facilities that are under the board's jurisdiction. This rule establishes reporting requirements to provide consumers, the board, and electric utilities with methodology for monitoring reliability and ensuring quality of electric service within an electric utility's operating area. This rule provides definitions and requirements for maintenance of interruption data, retention of records, and report filing.

20.18(3) *General obligations.*

a. Each electric utility shall make reasonable efforts to avoid and prevent interruptions of service. However, when interruptions occur, service shall be reestablished within the shortest time practicable, consistent with safety.

b. The electric utility's electrical transmission and distribution facilities shall be designed, constructed, maintained, and electrically reinforced and supplemented as required to reliably perform the power delivery burden placed upon them in the storm and traffic hazard environment in which they are located.

c. Each electric utility shall carry on an effective preventive maintenance program and shall be capable of emergency repair work on a scale which its storm and traffic damage record indicates as appropriate to its scope of operations and to the physical condition of its transmission and distribution facilities.

d. In appraising the reliability of the electric utility's transmission and distribution system, the board will consider the condition of the physical property and the size, training, supervision, availability, equipment, and mobility of the maintenance forces, all as demonstrated in actual cases of storm and traffic damage to the facilities.

e. Each electric utility shall keep records of interruptions of service on its primary distribution system and shall make an analysis of the records for the purpose of determining steps to be taken to prevent recurrence of such interruptions.

f. Each electric utility shall make reasonable efforts to reduce the risk of future interruptions by taking into account the age, condition, design, and performance of transmission and distribution facilities and providing adequate investment in the maintenance, repair, replacement, and upgrade of facilities and equipment.

g. Any electric utility unable to comply with applicable provisions of rule 20.18(476,478) may file a waiver request pursuant to rule 199—1.3(17A,474,476,78GA,HF2206).

20.18(4) *Definitions.* Terms and formulas when used in rule 20.18(476,478) are defined as follows:

"Customer" means (1) any person, firm, association, or corporation, (2) any agency of the federal, state, or local government, or (3) any legal entity responsible by law for payment of the electric service from the electric utility which has a separately metered electrical service point for which a bill is rendered. Electrical service point means the point of connection between the electric utility's equipment and the customer's equipment. Each meter equals one customer. Retail customers are end-use customers who purchase and ultimately consume electricity.

"Customer average interruption duration index (CAIDI)" means the average interruption duration for those customers who experience interruptions during the year. It is calculated by dividing the annual sum of all customer interruption durations by the total number of customer interruptions.

$$\text{CAIDI} = \frac{\text{Sum of All Customer Interruption Durations}}{\text{Total Number of Customer Interruptions}}$$

"Distribution system" means that part of the electric system owned or operated by an electric utility and designed to operate at a nominal voltage of 25,000 volts or less.

"Electric utility" means investor-owned electric utilities and electric cooperative corporations and associations owning, controlling, operating, or using transmission and distribution facilities and equipment subject to the board's jurisdiction.

"GIS" means a geospatial information system. This is an information management framework that allows the integration of various data and geospatial information.

"Interrupting device" means a device capable of being reclosed whose purpose is to interrupt faults and restore service or disconnect loads. These devices can be manual, automatic, or motor-operated. Examples may include transmission breakers, feeder breakers, line reclosers, motor-operated switches, fuses, or other devices.

"Interruption" means a loss of service to one or more customers or other facilities and is the result of one or more component outages. The types of interruption include momentary event, sustained, and

scheduled. The following interruption causes shall not be included in the calculation of the reliability indices:

1. Interruptions intentionally initiated pursuant to the provisions of an interruptible service tariff or contract and affecting only those customers taking electric service under such tariff or contract;
2. Interruptions due to nonpayment of a bill;
3. Interruptions due to tampering with service equipment;
4. Interruptions due to denied access to service equipment located on the affected customer's private property;
5. Interruptions due to hazardous conditions located on the affected customer's private property;
6. Interruptions due to a request by the affected customer;
7. Interruptions due to a request by a law enforcement agency, fire department, other governmental agency responsible for public welfare, or any agency or authority responsible for bulk power system security;
8. Interruptions caused by the failure of a customer's equipment; the operation of a customer's equipment in a manner inconsistent with law, an approved tariff, rule, regulation, or an agreement between the customer and the electric utility; or the failure of a customer to take a required action that would have avoided the interruption, such as failing to notify the company of an increase in load when required to do so by a tariff or contract.

"Interruption duration" as used herein in regard to sustained outages means a period of time measured in one-minute increments that starts when an electric utility is notified or becomes aware of an interruption and ends when an electric utility restores electric service. Durations of less than five minutes shall not be reported in sustained outages.

"Interruption, momentary" means single operation of an interrupting device that results in a voltage of zero. For example, two breaker or recloser operations equals two momentary interruptions. A momentary interruption is one in which power is restored automatically.

"Interruption, momentary event" means an interruption of electric service to one or more customers of duration limited to the period required to restore service by an interrupting device. Note: Such switching operations must be completed in a specified time not to exceed five minutes. This definition includes all reclosing operations that occur within five minutes of the first interruption. For example, if a recloser or breaker operates two, three, or four times and then holds, the event shall be considered one momentary event interruption.

"Interruption, scheduled" means an interruption of electric power that results when a transmission or distribution component is deliberately taken out of service at a selected time, usually for the purposes of construction, preventive maintenance, or repair. If it is possible to defer the interruption, the interruption is considered a scheduled interruption.

"Interruption, sustained" means any interruption not classified as a momentary event interruption. It is an interruption of electric service that is not automatically or instantaneously restored, with duration of greater than five minutes.

"Loss of service" means the loss of electrical power, a complete loss of voltage, to one or more customers. This does not include any of the power quality issues such as sags, swells, impulses, or harmonics. Also see definition of "interruption."

"Major event" will be declared whenever extensive physical damage to transmission and distribution facilities has occurred within an electric utility's operating area due to unusually severe and abnormal weather or event and:

1. Wind speed exceeds 90 mph for the affected area, or
2. One-half inch of ice is present and wind speed exceeds 40 mph for the affected area, or
3. Ten percent of the affected area total customer count is incurring a loss of service for a length of time to exceed five hours, or
4. 20,000 customers in a metropolitan area are incurring a loss of service for a length of time to exceed five hours.

"Meter" means, unless otherwise qualified, a device that measures and registers the integral of an electrical quantity with respect to time.

"Metropolitan area" means any community, or group of contiguous communities, with a population of 20,000 individuals or more.

"Momentary average interruption frequency index (MAIFI)" means the average number of momentary electric service interruptions for each customer during the year. It is calculated by dividing the total number of customer momentary interruptions by the total number of customers served.

$$\text{MAIFI} = \frac{\text{Total Number of Customer Momentary Interruptions}}{\text{Total Number of Customers Served}}$$

"OMS" is a computerized outage management system.

"Operating area" means a geographical area defined by the electric utility that is a distinct area for administration, operation, or data collection with respect to the facilities serving, or the service provided within, the geographical area.

"Outage" means the state of a component when it is not available to perform its intended function due to some event directly associated with that component. An outage may or may not cause an interruption of service to customers, depending on system configuration.

"Power quality" means the characteristics of electric power received by the customer, with the exception of sustained interruptions and momentary event interruptions. Characteristics of electric power that detract from its quality include waveform irregularities and voltage variations, either prolonged or transient. Power quality problems shall include, but are not limited to, disturbances such as high or low voltage, voltage spikes and transients, flickers and voltage sags, surges and short-time overvoltages, as well as harmonics and noise.

"Rural circuit" means a circuit not defined as an urban circuit.

"System average interruption duration index (SAIDI)" means the average interruption duration per customer served during the year. It is calculated by dividing the sum of the customer interruption durations by the total number of customers served during the year.

$$\text{SAIDI} = \frac{\text{Sum of All Customer Interruption Durations}}{\text{Total Number of Customers Served}}$$

"System average interruption frequency index (SAIFI)" means the average number of interruptions per customer during the year. It is calculated by dividing the total annual number of customer interruptions by the total number of customers served during the year.

$$\text{SAIFI} = \frac{\text{Total Number of Customer Interruptions}}{\text{Total Number of Customers Served}}$$

"Total number of customers served" means the total number of customers served on the last day of the reporting period.

"Urban circuit" means a circuit where both 75 percent or more of its customers and 75 percent or more of its primary circuit miles are located within a metropolitan area.

20.18(5) *Record-keeping requirements.*

a. Required records for electric utilities with over 50,000 Iowa retail customers.

(1) Each electric utility shall maintain a geospatial information system (GIS) and an outage management system (OMS) sufficient to determine a history of sustained electric service interruptions experienced by each customer. The OMS shall have the ability to access data for each customer in order to determine a history of electric service interruptions. Data shall be sortable by each of, and in any combination with, the following factors:

1. State jurisdiction;
2. Operating area (if any);
3. Substation;

4. Circuit;
5. Number of interruptions in reporting period; and
6. Number of hours of interruptions in reporting period.

(2) Records on interruptions shall be sufficient to determine the following:

1. Starting date and time the utility became aware of the interruption;
2. Duration of the interruption;
3. Date and time service was restored;
4. Number of customers affected;
5. Description of the cause of the interruption;
6. Operating areas affected;
7. Circuit number(s) of the distribution circuit(s) affected;
8. Service account number or other unique identifier of each customer affected;
9. Address of each affected customer location;
10. Weather conditions at time of interruption;
11. System component(s) involved (e.g., transmission line, substation, overhead primary main, underground primary main, transformer); and
12. Whether the interruption was planned or unplanned.

(3) Each electric utility shall maintain as much information as feasible on momentary interruptions.

(4) Each electric utility shall keep information on cause codes, weather codes, isolating device codes, and equipment failed codes.

1. The minimum interruption cause code set should include: animals, lightning, major event, scheduled, trees, overload, error, supply, equipment, other, unknown, and earthquake.
2. The minimum interruption weather code set should include: wind, lightning, heat, ice/snow, rain, clear day, and tornado/hurricane.
3. The minimum interruption isolating device set should include: breaker, recloser, fuse, sectionalizer, switch, and elbow.
4. The minimum interruption equipment failed code set should include: cable, transformer, conductor, splice, lightning arrester, switches, cross arm, pole, insulator, connector, other, and unknown.
5. Utilities may augment the code sets listed above to enhance tracking.

(5) An electric utility shall retain for seven years the records required by 20.18(5)*"a"*(1) through (4).

(6) Each electric utility shall record the date of installation of major facilities (poles, conductors, cable, and transformers) installed on or after April 1, 2003, and integrate that data into its GIS database.

b. Required records for all other electric utilities.

(1) Each electric utility, other than those providing only wholesale electric service, shall record and maintain sufficient records and reports that will enable it to calculate for the most recent seven-year period the average annual hours of interruption per customer due to causes in each of the following four major categories: power supplier, major storm, scheduled, and all other. Those electric utilities that provide only wholesale electric service shall provide their wholesale customers with the information necessary to allow those customers to ascertain the cause of power supply-related outages.

The category "scheduled" refers to interruptions resulting when a distribution transformer, line, or owned substation is deliberately taken out of service at a selected time for maintenance or other reasons.

The interruptions resulting from either scheduled or unscheduled outages on lines or substations owned by the power supplier are to be accounted for in the "power supplier" category.

The category "major storm" represents service interruptions from conditions that cause many concurrent outages because of snow, ice, or wind loads that exceed design assumptions for the lines.

The "all other" category includes outages primarily resulting from emergency conditions due to equipment breakdown, malfunction, or human error.

(2) When recording interruptions, each electric utility, other than those providing only wholesale electric service, shall use detailed standard codes for interruption analysis recommended by the United States Department of Agriculture, Rural Utilities Service (RUS) Bulletin 161-1, Tables 1 and 2, including the major cause categories of equipment or installation, age or deterioration, weather, birds or animals,

member (or public), and unknown. The utility shall also include the subcategories recommended by RUS for each of these major cause categories.

(3) Each electric utility, other than those providing only wholesale electric service, shall also maintain and record data sufficient to enable it to compute systemwide calculated indices for SAIFI-, SAIDI-, and CAIDI-type measurements, once with the data associated with "major storms" and once without.

c. Each electric utility shall make its records of customer interruptions available to the board as needed.

20.18(6) *Notification of major events.* Notification and reporting of major events as defined in subrule 20.18(4) shall comply with the requirements of rule 20.19(476,478).

20.18(7) *Annual reliability and service quality report for utilities with more than 50,000 Iowa retail customers.* Each electric utility with over 50,000 Iowa retail customers shall submit to the board and consumer advocate on or before May 1 of each year an annual reliability report for the previous calendar year for the Iowa jurisdiction. The report shall include the following information:

a. Description of service area. Urban and rural Iowa service territory customer count, Iowa operating area customer count, if applicable, and major communities served within each operating area.

b. System reliability performance.

(1) An overall assessment of the reliability performance, including the urban and rural SAIFI, SAIDI, and CAIDI reliability indices for the previous calendar year for the Iowa service territory and each defined Iowa operating area, if applicable. This assessment shall include outages at the substation, transmission, and generation levels of the system that directly result in sustained interruptions to customers on the distribution system. These indices shall be calculated twice, once with the data associated with major events and once without. This assessment should contain tabular and graphical presentations of the trend for each index as well as the trends of the major causes of interruptions.

(2) The urban and rural SAIFI, SAIDI, and CAIDI reliability average indices for the previous five calendar years for the Iowa service territory and each defined Iowa operating area, if applicable. The reliability average indices shall include outages at the substation, transmission, and generation levels of the system that directly result in sustained interruptions to customers on the distribution system. Calculation of the five-year average shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal a complete five-year average shall be available. These indices shall be calculated twice, once with the data associated with major events and once without.

(3) The MAIFI reliability indices for the previous five calendar years for the Iowa service territory and each defined Iowa operating area for which momentary interruptions are tracked. The first annual report should specify which portions of the system are monitored for momentary interruptions, identify and describe the quality of data used, and update as needed in subsequent reports.

c. Reporting on customer outages.

(1) The reporting electric utility shall provide tables and graphical representations showing, in ascending order, the total number of customers that experienced set numbers of sustained interruptions during the year (i.e., the number of customers who experienced zero interruptions, the number of customers who experienced one interruption, two interruptions, three interruptions, and so on). The utility shall provide this for each of the following:

1. All Iowa customers, excluding major events.
2. All Iowa customers, including major events.

(2) The reporting electric utility shall provide tables and graphical representations showing, in ascending order, the total number of customers that experienced a set range of total annual sustained interruption duration during the year (i.e., the number of customers who experienced zero hours total duration, the number of customers who experienced greater than 0.0833 but less than 0.5 hour total duration, the number of customers who experienced greater than 0.5 but less than 1.0 hour total duration, and so on, reflecting half-hour increments of duration). The utility shall provide this for each of the following:

1. All Iowa customers, excluding major events.

2. All Iowa customers, including major events.

d. Major event summary. For each major event that occurred in the reporting period, the following information shall be provided:

(1) A description of the area(s) impacted by each major event;

(2) The total number of customers interrupted by each major event;

(3) The total number of customer-minutes interrupted by each major event; and

(4) Updated damage cost estimates to the electric utility's facilities.

e. Information on transmission and distribution facilities.

(1) Total circuit miles of electric distribution line in service at year's end, segregated by voltage level. Reasonable groupings of lines with similar voltage levels, such as but not limited to 12,000- and 13,000-volt three-phase facilities, are acceptable.

(2) Total circuit miles of electric transmission line in service at year's end, segregated by voltage level.

f. Plans and status report.

(1) A plan for service quality improvements, including costs, for the electric utility's transmission and distribution facilities that will ensure quality, safe, and reliable delivery of energy to customers.

1. The plan shall cover not less than the three years following the year in which the annual report was filed. A copy of the electric utility's documents and databases supporting capital investment and maintenance budget amounts required in 20.18(7)*"g"*(1) and 20.18(7)*"h"*(1), respectively, (including but not limited to transmission and distribution facilities, transmission and distribution control and communication facilities, and transmission and distribution planning, maintenance, and reliability-related computer hardware and software) shall be maintained in the utility's principal Iowa business location and shall be available for inspection by the board and office of consumer advocate. The utility's plan may reference said budget documents and databases, instead of duplicating or restating the detail therein. Copies of capital budgeting documents shall be maintained for five years.

2. The plan shall identify reliability challenges and may describe specific projects and projected costs. The filing of the plan shall not be considered as evidence of the prudence of the utility's reliability expenditures.

3. The plan shall provide an estimate of the timing for achievement of the plan's goals.

(2) A progress report on plan implementation. The report shall include identification of significant changes to the prior plan and the reasons for the changes.

g. Capital expenditure information. Reporting of capital expenditure information shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal five years of data shall be available in each subsequent annual report.

(1) Each electric utility shall report on an annual basis the total of:

1. Capital investment in the electric utility's Iowa-based transmission and distribution infrastructure approved by its board of directors or other appropriate authority. If any amounts approved by the board of directors are designated for use in a recovery from a major event, those amounts shall be identified in addition to the total.

2. Capital investment expenditures in the electric utility's Iowa-based transmission and distribution infrastructure. If any expenditures were utilized in a recovery from a major event, those amounts shall be identified in addition to the total.

(2) Each electric utility shall report the same capital expenditure data from the past five years in the same fashion as in 20.18(7)*"g"*(1).

h. Maintenance. Reporting of maintenance information shall start with data from the year covered by the first Annual Reliability Report submittal so that by the fifth Annual Reliability Report submittal five years of data shall be available in each subsequent annual report.

(1) Total maintenance budgets and expenditures for distribution, and for transmission, for each operating area, if applicable, and for the electric utility's entire Iowa system for the past five years. If any maintenance budgets and expenditures are designated for use in a recovery from a major event, or were used in a recovery from a major event, respectively, those amounts shall be identified in addition to the totals.

(2) Tree trimming.

1. The budget and expenditures described in 20.18(7)*"h"*(1) shall be stated in such a way that the total annual tree trimming budget expenditures shall be identifiable for each operating area and for the electric utility's entire Iowa system for the past five years.

2. Total annual projected and actual miles of transmission line and of distribution line for which trees were trimmed for the reporting year for each operating area and for the electric utility's entire Iowa system for the reporting year, compared to the past five years. If the utility has utilized, or would prefer to utilize, an alternative method or methods of tracking physical tree trimming progress, it may propose the use of that method or methods to the board in a request for waiver.

3. In the event the utility's actual tree trimming performance, based on how the utility tracks its tree trimming as described in 20.18(7)*"h"*(2)"1," lags behind its planned trimming schedule by more than six months, the utility shall be required to file for the board's approval additional tree trimming status reports on a quarterly basis. Such reports shall describe the steps the utility will take to remediate its tree trimming performance and backlog. The additional quarterly reports shall continue until the utility's backlog has been reduced to zero.

i. The annual reliability report, starting with the reliability report for calendar year 2008, shall include the number of poles inspected, the number rejected, and the number replaced.

20.18(8) *Annual report for all electric utilities not reporting pursuant to 20.18(7).*

a. By July 1, 2003, each electric utility shall adopt and have approved by its board of directors or other governing authority a reliability plan and shall file an informational copy of the plan with the board. The plan shall be updated not less than annually and shall describe the following:

(1) The utility's current reliability programs, including:

1. Tree trimming cycle, including descriptions and explanations of any changes to schedules and procedures reportable in accordance with 199 IAC 25.3(3)*"c"*;

2. Animal contact reduction programs, if applicable;

3. Lightning outage mitigation programs, if applicable; and

4. Other programs the electric utility may identify as reliability-related.

(2) Current ability to track and monitor interruptions.

(3) How the electric utility plans to communicate its plan with customers/consumer owners.

b. By April 1, 2004, and each April 1 thereafter, each electric utility shall prepare for its board of directors or other governing authority a reliability report. A copy of the annual report shall be filed with the board for informational purposes, shall be made publicly available in its entirety to customers/consumer owners, and shall report on at least the following:

(1) Measures of reliability for each of the five previous calendar years, including reliability indices if required in 20.18(5)*"b"*(3). These measures shall start with data from the year covered by the first Annual Reliability Report so that by the fifth Annual Reliability Report submittal reliability measures will be based upon five years of data.

(2) Progress on any reliability programs identified in its plan, but not less than the applicable programs listed in 20.18(8)*"a"*(1).

20.18(9) *Inquiries about electric service reliability.*

a. For electric utilities with over 50,000 Iowa retail customers. A customer may request a report from an electric utility about the service reliability of the circuit supplying the customer's own meter. Within 20 working days of receipt of the request, the electric utility shall supply the report to the customer at a reasonable cost. The report should identify which interruptions (number and durations) are due to major events.

b. Other utilities are encouraged to adopt similar responses to the extent it is administratively feasible.

199—20.19(476,478) Notification and reporting of outages.

20.19(1) *Notification.* Each electric utility shall notify the board of any outage that results, or is expected to result, in the following:

a. Loss of service for more than two hours to substantially all of a municipality, including the surrounding area served by the same utility;

b. Loss of service for more than two hours to 20 percent of the customers in a utility's established zone or area;

c. Loss of service for more than two hours to more than 3,600 customers in a metropolitan area;

d. A major event as defined in subrule 20.18(4); or

e. Any other outage considered significant by the electric utility.

20.19(2) *Information required.*

a. Notice shall be provided as soon as the utility learns of the outage, or as soon as practical thereafter, by calling the board duty officer at 515-745-2332. The caller shall leave a call-back number for a person who can provide the following information:

(1) The nature or cause of the outage;

(2) The area affected;

(3) The number of customers that have experienced a loss of electric service as a result of the outage;

(4) The estimated time until service will be restored; and

(5) The name of the utility, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the outage.

b. The electric utility shall provide updates to the board as new or additional information becomes available until all service is restored.

20.19(3) *Outage report.* Each electric utility shall submit a report to the board within 30 days after the customers affected by the outage reported under subrule 20.19(1) have regained service. The report shall include the following:

a. A description of the circumstances that caused the outage;

b. The total number of customers out of service during the outage;

c. The longest customer interruption;

d. The damage cost estimates to the electric utility's facilities; and

e. The number of people used to restore service.

These rules are intended to implement Iowa Code sections 17A.3, 364.23, 474.5, 476.1, 476.2, 476.6, 476.8, 476.20, 476.54, 476.66, 478.18, and 546.7.

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[1] Effective date of 20.3(13) *"a," "b,"* (1), (2), (3), (4), and *"c"* delayed 70 days by Administrative Rules Review Committee.

[2] Effective date of 20.4(12), third unnumbered paragraph, delayed seventy days by the Administrative Rules Review Committee.

[3] See IAB, Utilities Division.

[4] Published in Notice portion of IAB 9/10/86; see IAB 10/22/86

[5] Effective date of 20.4(4) delayed until the adjournment of the 1994 Session of the General Assembly pursuant to Iowa Code section 17A.8(9) by the Administrative Rules Review Committee at its meeting held September 15, 1993.

CHAPTER 25
IOWA ELECTRICAL SAFETY CODE
[Prior to 10/8/86, Commerce Commission[250]]

199—25.1(476,476A,478) General information.

25.1(1) *Authority.* The standards relating to electric and communication facilities in this chapter are prescribed by the Iowa utilities board pursuant to Iowa Code sections 476.1, 476.1B, 476.2, 476A.12, 478.19, and 478.20.

25.1(2) *Purpose.* The purpose of this chapter is to promote safe and adequate service to the public, to provide standards for uniform and reasonable practices by utilities, and to establish a basis for determining the reasonableness of such demands as may be made by the public upon the utilities. The rules apply to electric and communication utility facilities located in the state of Iowa and shall supersede all conflicting rules of any such utility. This rule shall in no way relieve any utility from any of its duties under the laws of this state.

199—25.2(476,476A,478) Iowa electrical safety code defined. The standard minimum requirements for the installation and maintenance of electric substations, generating stations, and overhead and underground electric supply or communications lines adopted below, collectively constitute the "Iowa Electrical Safety Code."

25.2(1) *National Electrical Safety Code.* The American National Standards Institute (ANSI) C2-2007 "National Electrical Safety Code" (NESC) as ultimately conformed to the ANSI-approved draft by correction of publishing errors through issuance of printed corrections is adopted as part of the Iowa electrical safety code, except Part 4, "Rules for Operation of Electric Supply and Communications Lines and Equipment," which is not adopted by the board.

25.2(2) *Modifications and qualifications to ANSI C2.* The standards set forth in ANSI C2 are modified or qualified as follows:

a. Introduction to the National Electrical Safety Code.

(1) The following paragraph replaces NESC 011B: "The National Electrical Safety Code (NESC) covers utility facilities and functions from the point of generation by the utility, or delivery from another entity, of electricity or communications signals through the utility system to the point of delivery to a customer's facilities."

(2) NESC 013A2 is modified to read as follows: "Types of construction and methods of installation other than those specified in the rules may be used experimentally to obtain information, if done where:

1. Qualified supervision is provided,
2. Equivalent safety is provided,
3. On joint-use facilities, all affected parties agree, and
4. Prior approval is obtained from the Iowa utilities board."

b. Minimum clearances.

(1) In any instance where minimum clearances are provided in Iowa Code chapter 478 which are greater than otherwise required by these rules, the statutory clearances shall prevail.

(2) The following clearances shall apply to all lines regardless of date of construction: NESC 232, vertical clearances for "Water areas not suitable for sailboating or where sailboating is prohibited," "Water areas suitable for sailboating. . .," and "Established boat ramps and associated rigging areas. . ."; and NESC 234E, "Clearance of Wires, Conductors, Cables or Unguarded Rigid Live Parts Installed Over or Near Swimming Areas With No Wind Displacement."

(3) Table 232-1, Footnote 21, is changed to read: "Where the U.S. Army Corps of Engineers or the state, or a surrogate thereof, issues a crossing permit, the clearances of that permit shall govern if equal to or greater than those required herein. Where the permit clearances are less than those required herein and water surface use restrictions on vessel heights are enforced, the permit clearances may be used."

(4) Except for clearances near grain bins, for measurements made under field conditions, the board will consider compliance with the overhead vertical line clearance requirements of Subsection 232 and Table 232-1 of the 1987 NESC indicative of compliance with the 1990 through 2007 editions of the

NESC. (For an explanation of the differences between 1987 and subsequent code edition clearances, see Appendix A of the 1990 through 2007 editions of the NESC.)

c. Reserved.

d. Rule 217C.1 is changed to read:

"The ground end of anchor guys exposed to pedestrian or vehicle traffic shall be provided with a substantial marker not less than eight feet long. The guy marker shall be of a conspicuous color such as yellow, orange, or red. Green, white, gray or galvanized steel colors are not reliably conspicuous against plant growth, snow, or other surroundings. Noncomplying guy markers shall be replaced as part of the utility's inspection and maintenance plan."

e. There is added to Rule 381G:

(3) Pad-mounted and other aboveground equipment not located within a fenced or otherwise protected area shall have affixed to its outside access door or cover a prominent "Warning" or other appropriate sign of highly visible color, warning of hazardous voltage and including the name of the utility. This rule shall apply to all signs placed or replaced after June 18, 2003.

f. There is added to the first paragraph of Rule 110.A.1, after the sentence stating, "Entrances not under observation of an authorized attendant shall be kept locked," the following sentences:

Entrances may be unlocked while authorized personnel are inside. However, if unlocked, the entrance gate must be fully closed, and must also be latched or fastened if there is a gate-latching mechanism.

g. Lines crossing railroad tracks shall comply with the additional requirements of 199 IAC 42.6(476), "Engineering standards for electric and communications lines."

25.2(3) *Grain bins.*

a. Electric utilities shall conduct annual public information campaigns to inform farmers, farm lenders, grain bin merchants, and city and county zoning officials of the hazards of and standards for construction of grain bins near power lines.

b. An electric utility may refuse to provide electric service to any grain bin built near an existing electric line which does not provide the clearances required by the American National Standards Institute (ANSI)C2-2007 "National Electrical Safety Code," Rule 234F. This paragraph *"b"* shall apply only to grain bins loaded by portable augers, conveyors or elevators and built after September 9, 1992, or to grain bins loaded by permanently installed augers, conveyors, or elevator systems installed after December 24, 1997.

25.2(4) *General rules.*

a. Joint-use construction. Where it is mutually agreeable between the electric supply company and the communication or cable television company, communication circuits or cables may be buried in the same trench or attached to the same supporting structure, provided this joint use is permitted by, and is constructed in compliance with, the Iowa electrical safety code.

b. Lines. In order to limit the residual currents and voltages arising from line unbalances, the resistance, inductance, capacitance and leakage conductance of each phase conductor of an electric supply circuit in any section shall be as nearly equal as practical to the corresponding quantities in the other phase conductors in the same section.

The ampacity of a multigrounded neutral conductor of an electric supply circuit shall be adequate for the load which it is required to carry. The ampacity of a multigrounded neutral conductor of an electric supply circuit shall not be less than 60 percent of that of any phase conductor with which it is associated, except for three phase four wire wye circuits where it shall have ampacity not less than 50 percent of that of any associated phase conductor. In no case shall the resistance of a multigrounded neutral conductor exceed 3.6 ohms per mile. (This does not modify the mechanical strength requirements for conductors.) A multigrounded conductor installed and utilized primarily for lightning shielding of the associated phase conductors need not comply with the above percentage ampacity requirements for neutral conductors.

Where the neutral conductor of the electric supply circuit is not multigrounded or in an inductive exposure involving communication or signal circuits and equipment where the controlling frequencies

are 360 Hertz or lower, any neutral conductor shall have the same ampacity as the phase conductors with which it is associated.

25.2(5) *Other references adopted.*

a. The "National Electrical Code," ANSI/NFPA 70-2008, is adopted as a standard of accepted good practice for customer-owned electrical facilities beyond the utility point of delivery, except for installations subject to the provisions of the state fire marshal standards in 661 IAC 504.1(103).

b. "The Lineman's and Cableman's Handbook," Eleventh Edition; Shoemaker, Thomas M. and Mack, James E.; New York, McGraw-Hill Book Co., is adopted as a recommended guideline to implement the "National Electrical Safety Code" or "National Electrical Code," and for developing the inspection and maintenance plans required by 199 IAC 25.3(476,478).

[**ARC 7962B**, IAB 7/15/09, effective 8/19/09]

199—25.3(476,478) Inspection and maintenance plans.

25.3(1) *Filing of plan.* Each electric utility shall adopt and file with the board a written plan for inspecting and maintaining its electric supply lines and substations (excluding generating stations) in order to determine the necessity for replacement, maintenance, and repair, and for tree trimming or other vegetation management. If the plan is amended or altered, revised copies of the appropriate plan pages shall be filed.

25.3(2) *Annual report.* Each utility shall include as part of its annual report to the board, as required by 199—Chapter 23, certification of compliance with each area of the inspection plan or a detailed statement on areas of noncompliance.

25.3(3) *Contents of plan.* The inspection plan shall include the following elements:

a. General. A listing of all counties or parts of counties in which the utility has electric supply lines in Iowa. If the utility has district or regional offices responsible for implementation of a portion of the plan, the addresses of those offices and a description of the territory for which they are responsible shall also be included.

b. Inspection of lines, poles, and substations.

(1) Inspection schedules. The plan shall contain a schedule for the periodic inspection of the various units of the utility's electric plant. The period between inspections shall be based on accepted good practice in the industry, but for lines and substations shall not exceed ten years for any given line or piece of equipment. Lines operated at 34.5 kV or above shall be inspected at least annually for damage and to determine the condition of the overhead line insulators.

(2) Inspection coverage. The plan shall provide for the inspection of all supply line and substation units within the adopted inspection periods and shall include a complete listing of all categories of items to be checked during an inspection.

(3) Conduct of inspections. Inspections shall be conducted in a manner conducive to the identification of safety, maintenance, and reliability concerns or needs.

(4) Instructions to inspectors. Copies of instructions or guide materials used by utility inspectors in determining whether a facility is in acceptable condition or in need of corrective action or further investigation.

c. Tree trimming or vegetation management plan.

(1) Schedule. The plan shall contain a schedule for periodic tree trimming or other measures to control vegetation growth under or along the various units of the utility's electric plant. The period between inspections shall be based on accepted good practice in the industry and may vary depending on the nature of the vegetation at different locations.

(2) Procedures. The plan shall include written procedures for vegetation management. The procedures shall promote the safety and reliability of electric lines and facilities. Where tree trimming is employed, practices shall be adopted that will protect the health of the tree and reduce undesirable regrowth patterns.

d. Pole inspections. Pole inspections shall periodically include an examination of the poles that includes tests in addition to visual inspection in appropriate circumstances. These additional tests may include sounding, boring, groundline exposure, and, if applicable, pole treatment.

25.3(4) *Records.* Each utility shall keep sufficient records to demonstrate compliance with its inspection and vegetation management plans. For each inspection unit, the records of line and substation inspections and pole inspections shall include the inspection date(s), the findings of the inspection, and the disposition or scheduling of repairs or maintenance found necessary during the inspection. For each inspection unit, the records of vegetation management shall include the date(s) during which the work was conducted. The records shall be kept until two years after the next periodic inspection or vegetation management action is completed or until all necessary repairs and maintenance are completed, whichever is longer.

25.3(5) *Guidelines.* Applicable portions of Rural Utilities Service (RUS) Bulletins 1730-1, 1730B-121, and 1724E-300 and "The Lineman's and Cableman's Handbook" are suggested as guidelines for the development and implementation of an inspection plan. ANSI A300 (Part 1)-2001, "Pruning," and Section 35 of "The Lineman's and Cableman's Handbook" are suggested as guides for tree trimming practices.

199—25.4(476,478) Correction of problems found during inspections. Corrective action shall be taken within a reasonable period of time on all potentially hazardous conditions, instances of safety code noncompliance, maintenance needs, potential threats to safety and reliability, or other concerns identified during inspections. Hazardous conditions shall be corrected promptly.

199—25.5(476,478) Accident reports. This rule applies to all owners or operators of electrical facilities subject to the safety jurisdiction of the board under this chapter.

25.5(1) All owners and operators of electrical facilities subject to the safety jurisdiction of the board shall provide the board with a 24-hour contact number where the board can obtain immediate access to a person knowledgeable about any incidents involving contact with energized electrical facilities.

25.5(2) All owners and operators of electrical facilities subject to the safety jurisdiction of the board shall notify the board of any incident or accident involving contact with energized electrical facilities that meets the following conditions:

a. An employee or other person coming in contact with energized electrical facilities which results in death or personal injury necessitating in-patient hospitalization.

b. Estimated property damage of $15,000 or more to the property of the utility and others.

c. Any other incident considered significant by the company.

25.5(3) The board shall be notified by telephone immediately, or as soon as practical thereafter, by calling the board duty officer at 515-745-2332. The caller shall leave a telephone number of a person who can provide the following information:

a. The name of the company, the name and telephone number of the person making the report, and the name and telephone number of a contact person knowledgeable about the incident.

b. The location of the incident.

c. The time of the incident.

d. The number of deaths or personal injuries requiring in-patient hospitalization and the extent of those injuries.

e. Initial estimate of damages.

f. A summary of the significant information available regarding the probable cause of the incident and extent of damages.

g. Any oral or written report made to a federal agency, the agency receiving the report, and the name and telephone number of the person who made or prepared the report.

25.5(4) Written incident reports. Within 30 days of the date of the incident, the owner or operator shall file a written report with the board. The report shall include the information required for telephone notice in subrule 25.5(2), the probable cause as determined by the company, the number and cause of any deaths or personal injuries requiring in-patient hospitalization, and a detailed description of property damage and the amount of monetary damages. If significant additional information becomes available

at a later date, a supplemental report shall be filed. Duplicate copies of any written reports filed with or submitted to a federal agency concerning the incident shall also be provided to the board.

These rules are intended to implement Iowa Code chapter 478.

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◊ Two or more ARCs

HISTORICAL DIVISION[223]

[Prior to 5/31/89, see Historical Department[490]
created under the "umbrella" of the Department of Cultural Affairs[221] by Iowa Code section 303.1]

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CHAPTER 48
HISTORIC PRESERVATION AND CULTURAL AND ENTERTAINMENT DISTRICT TAX CREDITS

223—48.1(303,404A) Purpose. A historic preservation and cultural and entertainment district tax credit (hereafter referred to as historic tax credit) for rehabilitation of eligible commercial property, residential property and barns located in this state is granted to approved projects, subject to availability of the credit, to apply against the income tax imposed under Iowa Code chapter 422, division II, III, or V, or Iowa Code chapter 432. Historic tax credits are restricted to rehabilitation projects for eligible properties in Iowa. Rehabilitation projects for eligible properties must be conducted in accordance with the federal Standards for Rehabilitation (36 CFR Part 67.7) as described in the U.S. Secretary of the Interior's Standards for the Treatment of Historic Properties (hereafter referred to as Standards).

223—48.2(303,404A) Definitions. The definitions listed in Iowa Code section 17A.2 and rules 223—1.2(17A,303), 223—1.6(303), 223—13.2(303), 223—22.2(303), and 223—35.2(303) shall apply to terms as they are used throughout this chapter. In addition, the following definitions apply:

"Applicant" means the person, partnership, corporation, qualifying nonprofit organization, or public agency applying for the tax credit. In most cases, this will be the entity holding a fee-simple interest in the property or any other person or entity recognized by the Internal Revenue Code for purposes of the applicable tax benefits. If an application is made by someone other than the fee-simple owner, the application must be accompanied by a written statement signed by the fee-simple owner indicating the fee-simple owner does not object to the applicant claiming the tax credit.

"Assessed value" means the amount of the most current property tax assessment.

"Barn" means an agricultural building or structure, in whatever shape or design, which is used for the storage of farm products or feed or for the housing of farm animals, poultry, or farm equipment.

"Commercial property" means a building used for retail, office, or other uses not otherwise defined in this rule.

"Disaster recovery project" means an eligible property located in an area declared a disaster area by the governor of Iowa or by the president of the United States. The property must have been physically impacted as a result of the disaster.

"Employment base" means the number of jobs that exist at an eligible property on the date part one of the application is approved.

"Historic tax credit(s)" means the historic preservation and cultural and entertainment district tax credit established in Iowa Code chapter 404A.

"Mixed-use property" means an eligible property that includes three or more residential units and may also contain a commercial property component in the same building.

"New permanent jobs" means the number of new jobs that exist at an eligible property two years after the tax credit certificate is issued. New permanent jobs are calculated as those over and above the employment base.

"Placed in service" means the date on which a building receives a certificate of occupancy from the applicable city or county official or the date on which the building is placed in a condition or state of readiness and availability for a specifically assigned function, whether in a trade or business, in the production of income, in a tax-exempt activity, or in a personal activity.

"Qualified rehabilitation costs" means qualified rehabilitation expenditures under the federal rehabilitation credit in Section 47 of the Internal Revenue Code.

"Qualifying nonprofit organization" means an organization, other than governmental bodies, described in Section 501 of the Internal Revenue Code unless the exemption is denied under Section 501, 502, 503 or 504 of the Internal Revenue Code.

"Reserved tax credit" means the amount of tax credits set aside from the available tax credit fund for an approved project.

"Residential property" means a building with two or fewer residential units, with each unit providing complete, independent living facilities for one or more persons, including permanent provisions for living, sleeping, eating, cooking, and sanitation.

"Standards" means the Standards for Rehabilitation as described in the U.S. Secretary of the Interior's Standards for the Treatment of Historic Properties.

"Tax basis" means the same as defined in department of revenue 701—subrule 42.15(3).

"Tax credit year" means the tax year in which a tax credit certificate holder is eligible to redeem a tax credit certificate based on the availability of tax credits for an eligible project.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.3(303,404A) Eligible properties. The following properties are eligible for the historic tax credit:

1. Property verified as listed on the National Register of Historic Places or determined eligible for such listing through the established procedures of the state historic preservation office (SHPO);
2. Property designated as a building contributing to the historic significance of a district listed on the National Register of Historic Places or contributing to the historic significance of a district determined eligible for such listing through the established procedures of the SHPO;
3. A property or district designated as a local landmark by a city or county ordinance; or
4. A barn constructed prior to 1937.

223—48.4(303,404A) Qualified and nonqualified rehabilitation costs.

48.4(1) Qualified rehabilitation costs are as defined in Section 47, rehabilitation credit, of the Internal Revenue Code.

48.4(2) Costs deducted as expenses in the tax year in which they are paid or incurred are nonqualified rehabilitation costs for determination of historic tax credits.

48.4(3) Architectural and engineering fees, site survey fees, legal fees, insurance premiums, development fees and other construction-related expenses are qualified rehabilitation costs for determination of historic tax credits to the extent they increase the tax basis of the eligible property.

48.4(4) Sidewalk, parking lot and landscaping expenses are nonqualified rehabilitation costs for determination of historic tax credits.

48.4(5) Only qualified rehabilitation costs incurred during the 24-month period immediately prior to the date the building was placed in service may be used for determination of historic tax credits, excluding any costs incurred prior to inception of this program.

a. Qualified rehabilitation costs incurred prior to approval by the SHPO of part two of the application (see rule 223—48.6(303,404A)) may be considered in the determination of historic tax credits.

b. Applicants who undertake rehabilitation projects without prior approval from the SHPO do so at their own risk.

48.4(6) Any submission of a part three of the application with qualified rehabilitation costs of more than $500,000 shall include a certified statement by a certified public accountant verifying that the expenses statement includes only qualified rehabilitation costs incurred in the time period established in subrule 48.4(5).

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.5(303,404A) Rehabilitation cost limits and amount of credit.

48.5(1) For commercial or mixed-use property, the amount of rehabilitation costs must equal at least 50 percent of the assessed value of the property, excluding the land, prior to rehabilitation.

48.5(2) For residential property or for barns, the amount of rehabilitation costs must equal at least $25,000 or 25 percent of the assessed value of the property, excluding the land, prior to rehabilitation, whichever is less.

48.5(3) For residential or mixed-use property, the amount of rehabilitation costs shall not exceed $100,000 per residential unit excluding any qualified rehabilitation costs for the public or commercial

space and excluding any qualified rehabilitation costs for the weather surfaces of the building envelope including exterior windows and doors.

48.5(4) The historic tax credit for a project shall equal 25 percent of the qualified rehabilitation costs.

48.5(5) Applicants may develop subsequent projects for qualified rehabilitation costs not previously included in a tax credit application for a building which had tax credits previously reserved or awarded. Each subsequent application shall meet eligibility requirements as stated in subrules 48.5(1) to 48.5(4) and shall be reviewed individually and independently.

a. Applicants who select to phase their work under the federal historic tax credit program may submit individual state applications for each phase of the federal project. Phased federal projects shall not apply for the small projects fund.

b. For applicants receiving credits through the small projects fund, the cumulative total for multiple applications for a single building shall not exceed $500,000 in qualified rehabilitation costs. The SHPO will not accept an application for a building previously receiving credits through the small projects fund that causes the cumulative total to exceed $500,000. The applicant may either:

(1) Apply for the cumulative total of qualified rehabilitation costs under any other fund for which the project is eligible. If the applicant receives a tax credit reservation from another fund, the applicant shall abandon the entirety of the applicant's tax credit reservation in the small projects fund in accordance with rule 223—48.12(303,404A); or

(2) Apply for only the qualified rehabilitation costs up to a cumulative total of $500,000. If the applicant has already received and claimed a tax credit certificate on the applicant's annual tax return, the applicant shall select this option.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.6(303,404A) Application and review process.

48.6(1) All applications for historic tax credits shall be on the current state fiscal year's forms and in accordance with the current state fiscal year's instructions provided by the SHPO. All applications must be complete and include all required supporting documentation before being considered for review and before beginning the review periods outlined in subrule 48.6(3). Application forms are available from the Tax Incentives Program Manager, State Historic Preservation Office, Department of Cultural Affairs, 600 E. Locust Street, Des Moines, Iowa 50319-0290. Applications may also be downloaded from the department of cultural affairs—state historical society of Iowa Web site.

a. Part one of the application identifies the eligibility of the property for the historic tax credit. Part one of the application is accepted year-round. Part one of the application must include all requested information. SHPO staff shall notify the applicant if part one of the application is incomplete. Incomplete applications will not be processed.

b. Part two of the application provides a detailed description of the rehabilitation project. Part two of the application is accepted when tax credits are available for the fund specified by the applicant pursuant to subrule 48.7(6) or, if no tax credits are available, in accordance with rule 223—48.8(303,404A). Part two of the application must include all requested information. SHPO staff shall notify the applicant if part two of the application is incomplete. Incomplete applications will not be processed.

c. Part three of the application provides the information and documentation required to request certification of project completion and includes an economic impact questionnaire. Part three of the application shall be submitted within six months of the date on which the building is placed in service or, if the project is complete, part three of the application may be submitted simultaneously with part two of the application. Part three of the application must include all requested information including certification in accordance with subrule 48.4(6). SHPO staff shall notify the applicant if part three of the application is incomplete. Incomplete applications will not be processed. Incomplete applications may be subject to abandonment as outlined in rule 223—48.12(303,404A).

d. Amendments to applications. An applicant shall amend an approved part one of the application or an approved part two of the application if the property changes ownership or if the applicant's name or address changes. An applicant may amend an approved part two of the application to notify SHPO of, and to request review of, modifications to the original description of the rehabilitation project. Amendments

to part two of the application shall not include modification of the rehabilitation costs estimated in the originally approved part two of the application. Amendments to part two of the application shall not result in the reservation of additional tax credits for a project.

e. An application will not be accepted for a building placed in service more than five years before part two of the application is submitted.

48.6(2) SHPO staff trained by the National Park Service for reviewing rehabilitation projects to ensure compliance with Standards will review part two and part three of each submitted application.

48.6(3) SHPO staff shall review and respond to each part of a completed or amended application within 90 days of receipt when submitted pursuant to subrule 48.6(1). If an applicant submits more than one part of the application simultaneously, SHPO staff shall review each part sequentially and the 90-day review period for part two or three of the application will begin upon approval of the previous part.

48.6(4) A part two of an application that includes the same scope of work as a rehabilitation project which qualifies for the federal rehabilitation credit under Section 47 of the Internal Revenue Code shall automatically be approved when reviewed in accordance with subrule 48.6(7) and to the extent that all historic tax credits appropriated for the fiscal year have not already been reserved.

48.6(5) Response to application parts.

a. Review of part one of the application shall result in one of two responses:

(1) The property is eligible for the historic tax credit; or

(2) The property is not eligible for the historic tax credit.

b. Review of part two of the application shall result in one of three responses which may be provided to the department of revenue:

(1) The rehabilitation described in the application is consistent with the historic character of the property or the district in which it is located, and the project meets the Standards. The initial review of part two is a preliminary determination only. A formal certification of rehabilitation shall be issued only after rehabilitation work is completed;

(2) The rehabilitation or proposed rehabilitation described in part two of the application will meet the Standards if the stipulated conditions are met; or

(3) The rehabilitation described in part two of the application is not consistent with the historic character of the property or the district in which it is located, and the project does not meet the Standards. The application will not be approved and SHPO will not reserve tax credits for the project.

c. Review of part three of the application shall result in one of two responses which may be provided to the department of revenue:

(1) The completed rehabilitation meets the Standards and is consistent with the historic character of the property or the district in which it is located. Effective on the date of approval of part three of the application, the project shall be designated a "certified rehabilitation"; or

(2) The rehabilitation is not consistent with the historic character of the property or the district in which it is located, and the project does not meet the Standards. If the work cannot be corrected to meet the Standards, the SHPO shall recapture the tax credit reservation in accordance with the provisions of rule 223—48.12(303,404A).

d. Questions concerning specific tax consequences or interpretation of the state tax code must be addressed to the department of revenue.

48.6(6) Approval of part one of the application. Upon approval of part one of the application, an applicant may proceed to submission of part two of the application. If the applicant submitted part two of the application simultaneously, the SHPO shall complete review of part one of the application before reviewing part two of the application.

48.6(7) Approval of part two of the application.

a. Upon approval of part two of the application with no conditions, the SHPO shall reserve tax credits for the project in an amount equal to 25 percent of the estimated qualified rehabilitation costs for the earliest year in which tax credits are available in the appropriate fund, and the applicant may proceed to implement the project.

b. Upon approval of part two of the application with conditions, the SHPO shall reserve tax credits for the project in an amount equal to 25 percent of the estimated qualified rehabilitation costs for the

earliest year in which tax credits are available in the appropriate fund. The applicant may proceed to implement the project, and the applicant shall document compliance with the conditions.

c. An authorized representative of the SHPO, with due notice to the applicant, may inspect projects to determine if the work meets the Standards.

48.6(8) Approval of part three of the application. Upon approval of part three of the application, the SHPO shall issue a tax credit certificate to the applicant in an amount equal to 25 percent of the qualified rehabilitation costs as estimated in part two of the application for the tax credit year originally reserved for the project upon approval of part two of the application, unless the qualified rehabilitation costs in part three of the application differ from the estimated qualified rehabilitation costs in part two of the application.

a. If the qualified rehabilitation costs documented in part three of the application are less than the qualified rehabilitation costs estimated in part two of the application, the SHPO shall issue a certificate in an amount equal to 25 percent of the final qualified rehabilitation costs and return any unused tax credits to the tax credit fund from which they were reserved.

b. For projects with tax credits reserved from the small projects fund and final qualified rehabilitation costs of $500,000 or less: If the final qualified rehabilitation costs documented in part three of the application are greater than the qualified rehabilitation costs estimated in part two of the application, the SHPO shall issue tax credit certificates totaling 25 percent of the final qualified rehabilitation costs, with the initial tax credit certificate issued in the amount originally reserved for the project and the remainder for the earliest year in which tax credits are available in the small projects fund or, if no tax credits are available, in accordance with rule 223—48.8(303,404A).

c. For projects with tax credits reserved from the small projects fund and final qualified rehabilitation costs over $500,000: The SHPO shall notify the applicant that the applicant may either:

(1) Apply for the cumulative total of qualified rehabilitation costs under any other fund for which the project is eligible. If the applicant receives a tax credit reservation from another fund, the applicant shall abandon the entirety of the applicant's tax credit reservation in the small projects fund in accordance with rule 223—48.12(303,404A); or

(2) Claim only the final qualified rehabilitation costs up to $500,000. If the applicant chooses this option, the SHPO shall issue tax credit certificates totaling no more than $125,000 for the project, with the initial tax credit certificate issued in the amount originally reserved for the project and the remainder for the earliest year in which tax credits are available in the small projects fund or, if no tax credits are available, in accordance with rule 223—48.8(303,404A).

d. For projects with tax credits reserved from any other fund: If the final qualified rehabilitation costs documented in part three of the application are greater than the qualified rehabilitation costs estimated in part two of the application, the SHPO shall issue tax credit certificates totaling 25 percent of the final qualified rehabilitation costs in the same fund from which tax credits were initially awarded, with the initial tax credit certificate issued for the amount originally reserved for the project and the remainder for the earliest year in which tax credits are available in the appropriate fund or, if no tax credits are available, in accordance with rule 223—48.8(303,404A).

48.6(9) Disaster recovery projects. An applicant may apply for the disaster recovery fund as described in subrule 48.7(3) if the project meets the following requirements:

a. The initial submittal of part two of the application shall be made no later than the first filing window (see subrule 48.8(2)) that occurs after the five-year anniversary of the disaster declaration date. This time period may be waived in accordance with Iowa Code section 17A.9A. Petitions for waivers shall be directed to the Director, Department of Cultural Affairs, 600 E. Locust Street, Des Moines, Iowa 50319.

b. Disasters declared before January 1, 2008, will not be considered.

48.6(10) Projects creating new permanent jobs. An applicant may apply for the new permanent jobs fund as described in subrule 48.7(4) if the applicant meets the following requirements:

a. The applicant shall document the employment base for an eligible property on the date part one of the application is approved;

b. The applicant must provide information to SHPO documenting the creation of at least 500 new permanent jobs within two years of the date on which part three of the application is approved. This information shall be verified by the Iowa department of economic development using the process outlined in 261—Chapter 188, Iowa Administrative Code. If the Iowa department of economic development is unable to verify the number of new permanent jobs required, tax credits claimed by the applicant will be subject to repayment to the department of revenue and unclaimed credits shall be unavailable; and

c. The applicant (and any leaseholders or tenants, if applicable) must enter into a contract with the SHPO specifying the employment base, reporting mechanisms required to document 500 new permanent jobs, applicable dates for reporting, and the penalty incurred if reporting requirements are not met. If the contract is not executed before the building is placed in service, the SHPO shall recapture any tax credits reserved in accordance with rule 223—48.12(303,404A).

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.7(303,404A) Tax credit funds.

48.7(1) *The small projects fund.* The SHPO shall reserve 10 percent of the tax credit allocation for any tax credit year in a small projects fund for projects with final qualified rehabilitation costs totaling $500,000 or less.

a. At the end of each state fiscal year, any credits in the small projects fund that have not been reserved for small projects shall be available for small projects in subsequent fiscal years.

b. If the small projects fund is fully reserved, any applications for small projects received after full reservation of the small projects fund may be eligible for the statewide fund.

48.7(2) *The cultural and entertainment district and great places fund.* The SHPO shall reserve 30 percent of the tax credit allocation for any tax credit year in a cultural and entertainment district and great places project (CED-GP) fund for projects located in cultural and entertainment districts certified in accordance with Iowa Code section 303.3B or for projects identified in Iowa great places agreements developed in accordance with Iowa Code section 303.3C.

48.7(3) *The disaster recovery fund.* The SHPO shall reserve 20 percent of the tax credit allocation for any tax credit year in a disaster recovery fund for projects located in an area declared a disaster area by the governor of Iowa or by the president of the United States. The eligible property must have been physically impacted as a result of the natural disaster as documented in accordance with the current state fiscal year's forms and instructions. The initial application for the project must be submitted within the time frame provided by subrule 48.6(9).

48.7(4) *The new permanent jobs fund.* The SHPO shall reserve 20 percent of the tax credit allocation for any tax credit year in a new permanent jobs fund for projects that involve the creation of more than 500 new permanent jobs within two years of the date on which part three of the application is approved.

48.7(5) *The statewide fund.* The SHPO shall reserve the remaining percentage of the tax credit allocation for any tax year in a statewide fund, which is to be used for eligible projects throughout the state of Iowa. If the statewide fund is fully reserved before the end of the state fiscal year, subsequent applications will be accepted utilizing the procedures in rule 223—48.8(303,404A).

48.7(6) *Fund selection.* Part two of the application shall clearly indicate the fund for which the applicant is applying. Only one fund may be selected. Any applications not indicating a specific fund shall be considered for the statewide fund. If an application is not eligible for the fund selected, it shall be considered for the statewide fund.

48.7(7) *Disposition of unreserved credits.* In reference to the new permanent jobs fund, CED-GP fund, and disaster recovery fund, at the end of the filing window in any fiscal year, any tax credits that have not been reserved will be reallocated in the same fiscal year as follows:

a. Unreserved CED-GP fund and new permanent jobs fund credits will be reallocated to the disaster recovery fund.

b. Unreserved disaster recovery fund credits will be reallocated to the statewide fund.

c. For purposes of this subrule, the phrase "in any fiscal year" refers to each of the three fiscal years for which credits may be reserved pursuant to Iowa Code section 404A.4(5) as amended by 2009 Iowa Acts, Senate File 481, section 3.
[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.8(303,404A) Sequencing of applications for review.

48.8(1) *Order of review.* The SHPO anticipates the receipt of a large number of applications for historic tax credits for projects with qualified rehabilitation costs in excess of $500,000 at the beginning of each state fiscal year. At the start of each state fiscal year, the SHPO will utilize a project review sequencing and prioritization system to establish the order in which applications will be reviewed.

a. Applications for projects with qualified rehabilitation costs of $500,000 or less applying for credits from the small projects fund will be accepted and reviewed throughout the calendar year until all available credits from that fund are reserved. When all available credits are reserved from the small projects fund, subsequent applications will be accepted utilizing the procedures in subrules 48.8(2) to 48.8(7).

b. If all available credits are reserved before review of all projects submitted within the filing window specified in subrule 48.8(2), applications not reviewed will be returned to the applicant.

48.8(2) *Filing window.* Part two applications for state historic tax credits received during the first ten working days of the state fiscal year shall be included in a project review sequencing system to determine the order in which they will be reviewed. The filing window for applications submitted in July 2009 will be extended to August 7, 2009.

48.8(3) *Initial sequencing process.* An initial sorting process based on the status of the project application at the start of the state fiscal year will be used to associate applications with the appropriate initial sequencing category. Following initial sorting into a category and subcategory, each application within the assigned category and subcategory will be sequenced in accordance with subrule 48.8(4).

a. Category A projects do not need to be resubmitted during the filing window and are comprised of two subcategories in the following order:

(1) Projects reviewed in the previous year's sequencing and review process that did not receive a reservation for the full 25 percent of their qualified rehabilitation costs.

(2) Projects with final qualified rehabilitation costs documented in part three of the application in excess of the estimated rehabilitation costs in part two pursuant to paragraph 48.6(8)*"b"* and which could not be otherwise reserved from available credits in the appropriate fund.

b. Category B projects are comprised of projects for which part two of a state historic tax credit application was submitted during any previous year's filing window, as verified by records maintained at the SHPO, and was included in that year's sequencing system, and did not receive a tax credit reservation. Category B projects must be resubmitted during the current year's filing window and must specify a fund pursuant to subrule 48.7(6). Category B projects will be divided into subcategories arranged in the following order:

(1) Projects will be included in a subcategory for the state fiscal year of original submission provided the project was included in each successive state fiscal year's sequencing system and did not receive a tax credit reservation. These subcategories will be arranged chronologically beginning with the earliest state fiscal year.

(2) Any projects for which applications were not submitted in successive state fiscal years will be included in a subcategory after those defined in subparagraph 48.8(3)*"b"*(1).

c. Category C projects are comprised of an entirely new part two of a state historic tax credit application not meeting the requirements for any other category and having been received within the specified filing window. Projects may consist of parts one and two of the application, parts two and three of the application with a part one having already been submitted, or parts one, two and three of the application. Category C projects must be submitted during the current year's filing window and must specify a fund pursuant to subrule 48.7(6).

48.8(4) *Secondary sequencing process.* Using a random number generator, SHPO staff will assign unique, random numbers to all applications that are eligible for inclusion in the review sequencing

system within each category and subcategory of the initial sequencing system. Applications within each category and subcategory shall then be placed in numeric order from lowest to highest. SHPO staff shall then create a master sequence list, with category A applications, arranged by subcategory, sequenced first; category B applications, arranged by subcategory, sequenced next; and category C applications sequenced last.

48.8(5) *Random number generator.* SHPO staff shall use a random number generator utility found in Microsoft Excel 2003 or the current version of Microsoft Excel generally used by the department of cultural affairs.

48.8(6) *Outside observer.* The initial sequencing process, the secondary sequencing process, and the development of the master sequence list will be observed and certified by an official state witness.

48.8(7) *Prioritization of review according to fund.* Once the master sequence list is set, the projects will be reviewed by fund in the sequential order in which they fall on the list.

a. Category A projects will be reviewed and reserved first. SHPO shall reserve the remaining credits for the project from the same tax credit fund selected by the applicant pursuant to subrule 48.7(6) if a selection was made. Otherwise, SHPO shall reserve the remaining credits for the project from the same tax credit fund from which the original reservation came or from another fund for which the project is eligible.

b. Following review of category A projects, tax credit funds will be reviewed in the following order:

(1) Small projects fund, CED-GP fund, and new permanent jobs fund.

(2) Disaster recovery fund.

(3) Statewide fund.

c. Any tax credits that have not been reserved in a particular fund will be transferred, if applicable, to the appropriate fund as outlined in rule 223—48.7(303,404A). If a fund is exhausted before the completion of reviews for that fund, all remaining projects in that fund shall be eligible for the statewide fund and will be considered in the order shown on the master sequence list.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.9(303,404A) Reserved tax credits.

48.9(1) Upon written approval of part two of the project application, the SHPO shall reserve an estimated tax credit under the name of the applicant(s) in an amount equal to 25 percent of the estimated qualified rehabilitation costs for the earliest year in which tax credits are available.

48.9(2) If the amount of estimated qualified rehabilitation costs changes during the course of project implementation, the applicant may include those costs in part three of the application.

48.9(3) The SHPO shall not reserve tax credits for more than two state fiscal years beyond the current state fiscal year.

48.9(4) Of the amount of tax credits that may be reserved in state fiscal years 2010, 2011, and 2012:

a. For state fiscal year 2010, SHPO will not reserve more than $20 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2009. SHPO will not reserve more than $30 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2010.

b. For state fiscal year 2011, SHPO will not reserve more than $20 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2010. SHPO will not reserve more than $30 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2011.

c. For state fiscal year 2012, SHPO will not reserve more than $20 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2011. SHPO will not reserve more than $30 million worth of tax credits that can be claimed on a tax return for a taxable year beginning on or after January 1, 2012.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.10(303,404A) Project commencement.

48.10(1) Once a tax credit reservation is made for a project, actual construction must begin on the project prior to the end of the state fiscal year in which the SHPO approved part two of the application. The applicant shall notify the SHPO of the commencement date of actual construction and, if the estimated qualified rehabilitation costs for the project exceed $500,000, shall submit a certified statement by a certified public accountant confirming expenditure of at least 10 percent of estimated qualified rehabilitation costs prior to the end of the state fiscal year in which the SHPO approved part two of the application.

48.10(2) In lieu of commencement of actual construction prior to the end of the state fiscal year in which the SHPO approved part two of the application, an applicant may notify the SHPO that the project identified in part two of the application was awarded low-income housing tax credits (LIHTC) from the Iowa finance authority in the same state fiscal year in which the SHPO approved part two of the application.

48.10(3) In the event actual construction on a project does not commence prior to the end of the state fiscal year in which the SHPO approved part two of the application in accordance with subrule 48.10(1) or 48.10(2), the SHPO shall recapture the tax credit reservation in accordance with the provisions of rule 223—48.12(303,404A).

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223—48.11(303,404A) Project completion.

48.11(1) Once a tax credit reservation is made for a project, construction must be completed and the building must be placed in service within 36 months of the date on which part two of the application is approved. For projects with tax credits reserved prior to July 1, 2009, construction must be completed and the building must be placed in service on or before June 30, 2011. The applicant must submit part three of the application within six months of the date on which the building is placed in service regardless of the 36-month deadline, unless part three of the application is submitted simultaneously with part two.

48.11(2) In the event actual construction on a project is not completed and the building is not placed in service within the time period allowed in accordance with subrule 48.11(1), the SHPO shall recapture the tax credit reservation in accordance with the provisions of rule 223—48.12(303,404A).

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.12(303,404A) Abandonment and recapture of tax credit reservation.

48.12(1) *Project abandonment due to inability to meet commencement deadline.* If the applicant has not provided the SHPO documentation of project commencement in accordance with rule 223—48.10(303,404A), the SHPO shall, by registered U.S. mail or courier sent to the last-known address of the applicant, request that the appropriate documentation be filed within 30 days of the date of the letter. If the SHPO has not received the documentation by the 30-day deadline, then the SHPO shall notify the applicant by registered U.S. mail or courier that the project has been abandoned and the tax credit reservation has been recaptured. If either letter is returned as undeliverable, the letter shall be filed and the tax credit reservation processed in accordance with subrule 48.12(5). Application processing fees for part two of the application as allowed by rule 223—48.16(303,404A) will not be returned.

48.12(2) *Project abandonment due to inability to meet project completion deadline.* If the applicant has not provided the SHPO documentation of project completion in accordance with rule 223—48.11(303,404A), the SHPO shall, by registered U.S. mail or courier sent to the last-known address of the applicant, request that part three of the application be filed within 30 days of the date of the letter. If the SHPO has not received part three of the application by the 30-day deadline, then the SHPO shall notify the applicant by registered U.S. mail or courier that the project has been abandoned and the tax credit reservation has been recaptured. If either letter is returned as undeliverable, the letter shall be filed and the tax credit reservation processed in accordance with subrule 48.12(5). Application processing fees for part two of the application as allowed by rule 223—48.16(303,404A) will not be returned.

48.12(3) *Project abandonment at the request of an applicant.* An applicant may choose to abandon tax credits reserved in accordance with subrule 48.6(7) at any time after the date on which the tax credit was reserved. A tax credit reservation may be voluntarily abandoned for any reason, including abandonment of a reservation from the small projects fund for consideration in another fund in accordance with paragraph 48.5(5)*"b"* or paragraph 48.6(8)*"c."* Submittal of a new application will require the submittal of a new processing fee. Processing fees for the original part two application(s) as allowed by rule 223—48.16(303,404A) will not be returned. To abandon a tax credit reservation, the applicant shall send a letter to the SHPO requesting that the tax credit project be abandoned. The SHPO shall notify the applicant by registered U.S. mail or courier that the project has been abandoned and the tax credit reservation has been recaptured. SHPO shall process the tax credit reservation in accordance with subrule 48.12(5).

48.12(4) *Tax credit recapture if part three of the application is not approved.* If as part of the SHPO review of part three of the application pursuant to subrule 48.6(5) rehabilitation work is found to be inconsistent with the historic character of the property or the district in which it is located and the applicant is unwilling or unable to correct the work accordingly, the SHPO shall notify the applicant by registered U.S. mail or courier that the tax credit reservation has been recaptured and shall process the tax credit reservation in accordance with subrule 48.12(5).

48.12(5) *Tax credit return to appropriate fund.* The SHPO shall return any recaptured tax credit reservations to the tax credit fund from which they were reserved.

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.13(303,404A) Transfer of tax credit certificate. The applicant may transfer the tax credit certificate to one or more parties in accordance with department of revenue 701—subrule 42.15(6).

223—48.14(303,404A) Redemption of tax credit certificate. The tax credit holder shall attach the tax credit certificate and a copy of the signed part three of the application to the taxpayer's state income tax return and submit these documents to the department of revenue in the tax year for which the tax credit certificate is valid.

223—48.15(303,404A) Tax credits in excess of tax liability.

48.15(1) An applicant whose tax credit exceeds the tax liability in the tax year for which the tax credit may be redeemed is entitled to a refund of the excess tax credit with interest under Iowa Code section 422.25. See also administrative rules of the department of revenue, particularly rules 701—42.15(422) and 701—52.18(422).

48.15(2) In lieu of a refund, the applicant may have the excess tax credit applied to the tax liability for the following year.

223—48.16(303,404A) Application processing fees. A nonrefundable fee for application processing of parts two and three of an application will be charged for review of requests for certification of a rehabilitation project for historic tax credits. An initial review fee will be due with the filing of part two of an application. An additional fee for review of completed rehabilitation work will be due with the filing of part three of an application. Fees will be based on the amount of qualified rehabilitation costs. The fee schedule is as follows:

For projects with qualified rehabilitation costs of:	Part 2 Processing Fee	Part 3 Processing Fee
$50,000 or less	No cost	No cost
$50,001 to $100,000	$250	$250
$100,001 to $500,000	$500	$500

$500,001 to $1,000,000	$750	0.5 percent of qualified rehabilitation costs (i.e., 0.005 × costs)
$1,000,001 to $6,000,000	$1,000	
Over $6,000,000	$1,500	$30,000

[**ARC 7943B**, IAB 7/15/09, effective 6/16/09]

223—48.17(303,404A) Appeals.

48.17(1) Applicants may appeal a decision of the SHPO on any of the following bases:

a. Action was outside statutory authority;

b. Decision was influenced by a conflict of interest;

c. Action violated state law or administrative rules;

d. Insufficient public notice was given; or

e. Alteration of the review and certification process was detrimental to the applicant.

48.17(2) Appeals in writing shall be delivered to the director of the department of cultural affairs within 30 days of the decision giving rise to the appeal. All appeals shall be directed to the Director, Department of Cultural Affairs, 600 E. Locust Street, Des Moines, Iowa 50319; telephone (515)281-7471.

48.17(3) All appeals shall contain:

a. The facts of the case;

b. Argument(s) in support of the appeal; and

c. The remedy sought.

48.17(4) The director of the department of cultural affairs shall consider and rule on an appeal after receiving all documentation from the appellant and shall notify the appellant in writing of the decision within 30 days. The decision of the director of the department of cultural affairs shall be final except as provided in Iowa Code sections 17A.19 and 17A.20.

48.17(5) Applicants may appeal SHPO decisions provided under subrule 48.6(5) regarding eligibility of a property to be placed on the National Register as determined during part one of the application and review process or regarding whether a proposed scope of work meets the Standards as determined during part two of the application and review process. The SHPO shall provide procedural guidance to the applicant should the applicant choose to appeal to the National Park Service under this subrule.

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These rules are intended to implement Iowa Code chapter 303 and chapter 404A as amended by 2009 Iowa Acts, Senate File 481.

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ECONOMIC DEVELOPMENT, IOWA DEPARTMENT OF[261]

[Created by 1986 Iowa Acts, chapter 1245]
[Prior to 1/14/87, see Iowa Development Commission[520] and Planning and Programming[630]]

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PART I
DEPARTMENT STRUCTURE

CHAPTER 1
ORGANIZATION

261—1.1(15) Mission. The Iowa department of economic development was established in 1986 pursuant to Iowa Code chapter 15. The authority delegated to the department had previously been delegated to the Iowa development commission and the office for planning and programming. The mission of the Iowa department of economic development is to continually improve the economic well-being of all Iowans by working in focused partnerships with businesses, entrepreneurs, communities and educational entities. The department's primary responsibilities are in the areas of finance, marketing, local government and service coordination, exporting, tourism, job training and entrepreneurial assistance, and small business.

261—1.2(15) Definitions. As used in these rules, unless the context otherwise requires:

"Board" or *"IDED board"* means the Iowa economic development board created by Iowa Code chapter 15.

"Department" or *"IDED"* means the Iowa department of economic development authorized by Iowa Code chapter 15.

"Director" means the director of the Iowa department of economic development or the director's designee.

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261—1.3(15) Iowa department of economic development board.

1.3(1) *Composition.*

a. Board size. The board consists of 15 voting members appointed by the governor and 7 ex officio nonvoting members. The ex officio nonvoting members are 4 legislative members, 2 state senators and 2 state representatives; 1 president, or the president's designee, of the University of Northern Iowa, University of Iowa, or Iowa State University of Science and Technology designated by the state board of regents on a rotating basis; 1 president, or the president's designee, of a private college or university appointed by the Iowa association of independent colleges and universities; and 1 superintendent, or the superintendent's designee, of a merged area school, appointed by the Iowa association of community college presidents.

b. Terms. Board members are appointed for four-year terms that begin and end as provided by Iowa Code section 69.19.

1.3(2) *Meetings.*

a. The board generally meets monthly at the department's offices located at 200 East Grand Avenue in Des Moines, Iowa. By notice of the regularly published meeting agendas, the board and its committees may hold regular or special meetings at other locations within the state. Meeting agendas are available on the department's Web site at www.iowalifechanging.com.

b. The board shall meet in May of each year for the purpose of receiving recommendations from the nominations committee, if established by the chairperson, and electing one of its voting members as chairperson and one of its voting members as vice chairperson. Nominations may also be made from the floor at the time of the election provided the consent of the nominee has been obtained. The chairperson and the vice chairperson shall not be from the same political party. The board shall meet at the call of the chairperson or when any eight members of the board file a written request with the chairperson for a meeting. Written notice of the time and place of each meeting shall be given to each member of the board. A majority of the voting members constitutes a quorum.

c. Any interested party may attend and observe board and committee meetings except for such portion as may be closed pursuant to Iowa Code section 21.5.

d. Observers may use cameras or recording devices during the course of a meeting so long as the use of such devices does not materially hinder the proceedings. The chairperson may order that the use

of these devices be discontinued if they cause interference and may exclude any person who fails to comply with that order.

e. Open session and closed session proceedings are electronically recorded. Minutes of open meetings are available for viewing at the department's offices.

1.3(3) *Duties.* The board shall perform the duties as outlined in Iowa Code section 15.104, and other functions as necessary and proper to carry out its responsibilities.

1.3(4) *Board committees.* The board shall establish the following statutorily authorized committees: a due diligence committee pursuant to Iowa Code section 15.103(6), a loan and credit guarantee committee pursuant to Iowa Code section 15.103(6) as amended by 2009 Iowa Acts, Senate File 344, section 18, and a technology commercialization committee pursuant to Iowa Code section 15.116 as amended by 2009 Iowa Acts, Senate File 344, section 22. The board may, from time to time, establish other standing committees that the board members deem necessary to assist the board in carrying out its duties. Meetings of standing committees are open to the public pursuant to Iowa Code chapter 21. The board chairperson may appoint such other ad hoc advisory committees as deemed necessary for specific purposes. An ad hoc committee appointed by the chairperson shall be comprised of less than a quorum of the board. Meetings of ad hoc committees or subcommittees appointed by the board chairperson are not open to the public.

1.3(5) *Standing committees.*

a. Due diligence committee. The due diligence committee shall be an advisory committee composed of voting members of the board elected annually by the voting members of the board. The size of the committee and the terms of committee members will be established annually by the board. Duties of the due diligence committee include, but are not limited to, carrying out any duties assigned by the board in relation to programs administered by the department, reviewing applications for financial assistance, conducting a thorough review of proposed projects and making recommendations to the board regarding funding. A majority of committee members constitutes a quorum. Nonvoting, ex officio members of the board may be appointed by the chairperson of the due diligence committee to serve on the due diligence committee as nonvoting, ex officio members.

b. Loan and credit guarantee committee. The loan and credit guarantee committee shall be an advisory committee composed of voting members of the board elected annually by the voting members of the board. The size of the committee and the terms of committee members will be established annually by the board. Duties of the loan and credit guarantee committee include, but are not limited to, carrying out any duties assigned by the board in relation to the loan and credit guarantee program administered by the department, reviewing loan and credit guarantee applications and making recommendations to the board regarding funding. A majority of committee members constitutes a quorum. Nonvoting, ex officio members of the board may be appointed by the chairperson to serve on the loan and credit guarantee committee as nonvoting, ex officio committee members. The loan and credit guarantee program was repealed by 2009 Iowa Acts, Senate File 344. This board committee shall continue to exist until the program has been closed out.

c. Technology commercialization committee. To evaluate and approve funding for projects and programs under Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2, the board shall create a technology commercialization committee composed of members with expertise in the areas of biosciences, engineering, manufacturing, pharmaceuticals, materials, information solutions, software, and energy. At least one member of the technology commercialization committee shall be a member of the economic development board. The size of the committee and the terms of committee members will be established annually by the board. An organization designated by the department, composed of members from both the public and private sectors and composed of subunits or subcommittees in the areas of already identified bioscience platforms, education and workforce development, commercialization, communication, policy and governance, and finance, shall provide funding recommendations to the technology commercialization committee. A majority of committee members constitutes a quorum.

d. Community and workforce development committee. The community and workforce development committee shall be an advisory committee to the board on workforce development matters.

The committee shall review and make recommendations regarding programs such as CDBG and HOME programs which include housing, public infrastructure and public facilities funding programs; main street Iowa and downtown resource center; tourism office; training programs established by Iowa Code chapters 260E, 260F and 260G; workforce and economic development training fund; and programs administered by the innovation and commercialization division such as internship, career awareness, up-skilling and related programs.

1.3(6) *Ad hoc committees.* The board chairperson or committee chairpersons, as applicable, may appoint ad hoc advisory committees and subcommittees that meet for specific, limited purposes including but not limited to:

a. Nominations committee. Prior to May 1 of each year, the board chairperson may appoint a nominations committee comprised of voting members of the board for the purpose of developing recommendations to the full board for the election of a board chairperson, vice-chairperson, and membership on the board's standing committees. Upon recommendation of the nominations committee, the board shall elect the members of the committees, and the board chairperson shall designate the chairpersons and vice-chairpersons of all committees.

b. Finance review committee. The board chairperson may appoint a finance review committee comprised of voting members of the board for the purpose of periodically meeting with department officials to review the department's regularly maintained financial records and other financial information requested by the board. The finance review committee may also attend audit entrance and exit interviews conducted by the auditor of state with department officials. The finance review committee is advisory only and may provide recommendations to the board.

c. Due diligence subcommittee. The due diligence committee chairperson may appoint a due diligence subcommittee comprised of voting members of the board for the purpose of reviewing requests for project extensions, amended awards, workouts and project restructures. The due diligence subcommittee is advisory only and may provide recommendations to the due diligence committee.

1.3(7) *Appeals of department of revenue decisions—wage-benefit tax credit program appeals.* A business whose application for a wage-benefit tax credit has been denied by the department of revenue may appeal the decision to the board. The appeal must be made in writing and received by the department within 30 days of the date on the notice of denial sent to the business by the department of revenue. The board may uphold or overturn the decision of the department of revenue. If the IDED board overturns the decision of the department of revenue, the department of revenue will be instructed, subject to availability, to issue a tax credit certificate.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—1.4(15) Department structure.

1.4(1) *General.* The department's organizational structure consists of the director, deputy director, and four divisions.

1.4(2) *Director.* The Iowa department of economic development is administered by a director appointed by the governor, who serves at the pleasure of the governor and is subject to confirmation by the senate. The director is the chief administrative officer of the department and in that capacity administers the programs and services of the department in compliance with applicable federal and state laws and regulations. The duties of the director are as authorized in Iowa Code section 15.106 and include preparing a budget subject to board approval, establishing an internal administrative structure and employing personnel, reviewing and submitting to the board legislative proposals, recommending rules to the board, reporting to the board on grants and contracts awarded by the department, and other actions to administer and direct the programs of the department.

The administrators of the four divisions and the deputy director report to the director.

1.4(3) *Deputy director.* The deputy director, appointed by the director, directs and administers the department in the director's absence.

1.4(4) *Divisions.* The director has established the following administrative divisions within the department in order to most efficiently and effectively carry out the department's responsibilities:

1. Administration division;

2. Business development division;
3. Community development division; and
4. Innovation and commercialization division.

1.4(5) *Attachment for administrative purposes; board support.* The Iowa department of economic development provides office space and staff support to the city development board pursuant to Iowa Code sections 368.9 and 15.108(3)*"a"*(2). The department provides administrative support to the vision Iowa board pursuant to Iowa Code section 15F.104 and the renewable fuel infrastructure board pursuant to Iowa Code section 15G.202.

1.4(6) *Advisory committees.* The director may appoint committees to serve in an advisory capacity to the department that are deemed necessary to accomplish the work of the department. The size of the committee and the terms of committee members will be established by the director. These committees may be dissolved as deemed appropriate by the director, and other committees may from time to time be established for specific purposes.

261—1.5(15) Information. The general public may obtain information about the Iowa department of economic development by contacting the Iowa Department of Economic Development, 200 East Grand Avenue, Des Moines, Iowa 50309; telephone (515)242-4700; or through the department's Web site at www.iowalifechanging.com.

These rules are intended to implement Iowa Code chapter 15 as amended by 2009 Iowa Acts, Senate File 344, chapter 15G as amended by 2009 Iowa Acts, Senate File 344, and section 17A.3.

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CHAPTER 23
IOWA COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM

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

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

"Activity" means one or more specific activities, projects or programs assisted with CDBG funds.

"Career link" means a program providing training and enhanced employment opportunities to the working poor and underemployed Iowans.

"CDBG" means community development block grant.

"EDSA" means economic development set-aside.

"HUD" means the U.S. Department of Housing and Urban Development.

"IDED" means the Iowa department of economic development.

"LMI" means low and moderate income. Households earning 80 percent or less of the area median income are LMI households.

"PFSA" means public facilities set-aside.

"Program income" means gross income a recipient receives that is directly generated by the use of CDBG funds, including funds generated by the use of program income.

"Program year" means the annual period beginning January 1 and ending December 31.

"Quality jobs program" means a job training program formerly funded with CDBG funds that is no longer operational.

"Recipient" means a local government entity awarded CDBG funds under any CDBG program.

"Sustainable community activities" means activities to develop viable communities while preserving precious environment and resources.

"Working poor" means an employed person with an annual household income between 25 and 50 percent of the area median family income.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—23.3(15) Eligible applicants. All incorporated cities and all counties in the state of Iowa, except those designated as entitlement areas by the U.S. Department of Housing and Urban Development, are eligible to apply for and receive funds under this program.

23.3(1) Any eligible applicant may apply directly or on behalf of a subrecipient.

23.3(2) Any eligible applicant may apply individually or jointly with another eligible applicant or other eligible applicants.

23.3(3) Applicants shall not apply on behalf of eligible applicants other than themselves.

261—23.4(15) Allocation of funds. IDED shall distribute CDBG funds as follows:

23.4(1) *Administration.* Two percent of total program funds including program income plus $100,000 shall be used for state administration.

23.4(2) *Technical assistance.* One percent of the funds shall be used for the provision of substantive technical assistance to recipients.

23.4(3) *Housing fund.* Twenty-five percent of the funds shall be reserved for a housing fund to be used to improve the supply of affordable housing for LMI persons.

23.4(4) *Job creation, retention and enhancement fund.* Twenty percent of the funds shall be reserved for a job creation, retention and enhancement fund to be for workforce development and to expand economic opportunities and job training for LMI persons. Job creation, retention and enhancement funds are awarded through three programs: the economic development set-aside (EDSA), the public facilities set-aside (PFSA), and career link. For CDBG federal program year 2008 only (October 1, 2007, through September 30, 2008), up to $5 million of funding normally allocated to this job creation, retention and enhancement fund may be allocated by the department to the contingency fund established in subrule 23.4(5). If reallocated, the funds will be used for disaster recovery activities.

23.4(5) *Contingency funds.* IDED reserves the right to allocate up to 5 percent of the funds for projects that address threats to public health and safety, or for disaster recovery activities, or for sustainable community demonstration projects. No more than $1 million may be utilized for sustainable community demonstration projects. For CDBG federal program year 2008 only (October 1, 2007, through September 30, 2008), an additional amount of up to $5 million of funding normally allocated to the job creation, retention and enhancement fund in subrule 23.4(4) may instead be allocated by the department to this contingency fund, and used for disaster recovery activities.

23.4(6) *Competitive program.* The remaining funds shall be available on a competitive basis through the water and sewer fund and community facilities and services fund. Of the remaining amount, 70 percent shall be reserved for the water and sewer fund, 15 percent shall be reserved for the community facilities and services fund and 15 percent shall be allocated to either the water and sewer fund or community facilities and services fund at the discretion of the director, based on requests for funds.

23.4(7) *Reallocation.* Any reserved funds not used for their specified purpose within the program year shall be reallocated in amounts and to funds as approved by the director to ensure the availability of resources to those funds in which the greatest need is demonstrated to exist or to respond to community or business needs.

23.4(8) *Recaptured funds.* Recaptured funds shall be available for use through the water and sewer fund, the community facilities and services fund, the contingency fund, the housing fund, and the downtown revitalization fund. As approved by the director, recaptured funds may be used to fund projects from the job creation, retention and enhancement fund in order to respond to an immediate business need if no funds are available through the economic development set-aside fund or public facilities set-aside fund. Recaptured funds remaining at the end of a program year shall be reallocated in amounts and to funds as approved by the director to ensure the availability of resources to those funds in which the greatest need is demonstrated to exist or to respond to a community or business need.

261—23.5(15) Common requirements for funding. Applications for funds under any of the CDBG programs shall meet the following minimum criteria:

23.5(1) Proposed activities shall be eligible, as authorized by Title I, Section 105 of the Housing and Community Development Act of 1974 and as further defined in 24 CFR 570, as revised April 1, 1997.

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

1. Primarily benefit low- and moderate-income persons. To address this objective, 51 percent or more persons benefiting from a proposed activity must have incomes at or below 80 percent of the area median income.
2. Aid in the prevention or elimination of slums and blight. To address this objective, the application must document the extent or seriousness of deterioration in the area to be assisted, showing a clear adverse effect on the well-being of the area or community and illustrating that the proposed activity will alleviate or eliminate the conditions causing the deterioration.
3. Meet an urgent community development need. To address this objective, the applicant must certify that the proposed activity is designed to alleviate existing conditions that pose a serious and immediate threat to the health or welfare of the community and that are recent in origin or that recently became urgent; that the applicant is unable to finance the activity without CDBG assistance and that other sources of funding are not available. A condition shall be considered recent if it developed or became urgent within 18 months prior to submission of the application for CDBG funds.

23.5(3) Applicants shall demonstrate capacity for grant administration. Administrative capacity shall be evidenced by previous satisfactory grant administration, availability of qualified personnel or plans to contract for administrative services. Funds used for administration shall not exceed 10 percent of the CDBG award amount or 10 percent of the total contract amount, except for awards made under the career link program, for which funds used for administration shall not exceed 5 percent of the CDBG award amount.

23.5(4) Applicants who have received previous CDBG awards shall have demonstrated acceptable past performance, including the timely expenditure of funds.

23.5(5) Applications shall demonstrate the feasibility of completing the proposed activities with the funds requested.

23.5(6) To the greatest extent feasible, applications shall propose the use of CDBG funds as gap financing. Applications shall identify and describe any other sources of funding for proposed activities.

23.5(7) Applications shall include a community development and housing needs assessment.

23.5(8) Negotiation of awards. IDED reserves the right to negotiate award amounts, terms and conditions prior to making any award under any program.

23.5(9) Applicants shall certify their compliance with the following:

1. The Civil Rights Act of 1964 (PL 88-352) and Title VIII of the Civil Rights Act of 1968 (PL 90-284) and related civil rights, fair housing and equal opportunity statutes and orders;
2. Title I of the Housing and Community Development Act of 1974;
3. Age Discrimination Act of 1975;
4. Section 504 of the Housing and Urban Development Act of 1973;
5. Section 3 of the Housing and Urban Development Act of 1968;
6. Davis-Bacon Act (40 U.S.C. 276a-5) where applicable under Section 100 of the Housing and Community Development Act of 1974;
7. Lead-Based Paint Poisoning Prevention Act;
8. 24 CFR Part 58 and the National Environmental Policy Act of 1969;
9. Uniform Relocation Assistance and Real Property Acquisition Act of 1979, Titles II and III;
10. Americans with Disabilities Act;
11. Section 102 of the Department of Housing and Urban Development Reform Act of 1989;
12. Contract Work Hours and Safety Act;
13. Copeland Anti-Kickback Act;
14. Fair Labor Standards Act;
15. Hatch Act;
16. Prohibition on the Use of Excessive Force and Barring Entrance;
17. Drug-Free Workplace Act;
18. Governmentwide Restriction on Lobbying;
19. Single Audit Act;
20. State of Iowa Citizen Participation Plan; and
21. Other relevant regulations as noted in the CDBG management guide.

261—23.6(15) Requirements for the competitive program.

23.6(1) *Restrictions on applicants.*

a. An applicant shall be allowed to submit one application per year under the water and sewer fund and one application per year under the community facilities and services fund.

b. An eligible applicant involved in a joint application (not as the lead applicant) shall be allowed to submit a separate, individual application only if the applicant is bound by a multijurisdictional agreement by state statute to provide a public service that is facilitated by the joint application and the activity proposed in the joint application is not located in the applicant's jurisdiction.

23.6(2) *Grant ceilings.* Maximum grant awards are as follows:

1. Applicants with populations of fewer than 1,000 shall apply for no more than $300,000.
2. Applicants with populations of 1,000 to 2,499 shall apply for no more than $500,000.
3. Applicants with populations of 2,500 to 14,999 shall apply for no more than $600,000.
4. Applicants with populations of 15,000 to 49,999 shall apply for no more than $800,000.

However, no recipient shall receive more than $1,000 per capita based on the total population within the recipient's jurisdiction. If a county applies on behalf of one or more unincorporated communities within its jurisdiction, the $1,000 per capita ceiling shall pertain to any project benefiting all residents of the unincorporated community or communities, not the entire unincorporated population of the county applying. Applicants shall use one of the following for population figures to determine the applicable grant ceilings: 2000 census figures, special census figures or adjusted figures based on annexation

completed in accordance with statutory requirements in Iowa Code chapter 368. County populations shall be calculated for unincorporated areas only to determine applicable grant ceilings.

a. Joint applications for sewer and water projects shall be awarded no more than the cumulative joint total allowed according to the population of each jurisdiction participating in the project. For all other joint applications, an application shall be awarded no more than one and one-half times the maximum amount allowed for either of the joint applicants.

b. Applicants may apply for the maximum amount for which they are eligible under both the sewer and water fund and community facilities and services fund.

c. Applicants may apply for multiple activities under each fund for an amount up to the applicable ceilings.

23.6(3) *Water and sewer fund application procedure.* IDED shall announce the availability of funds and instructions for applying for funds through direct mail, public notices, media releases, workshops or other means determined necessary by IDED.

a. Application forms shall be available upon request from IDED, Community Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309, or on the division's Web site at www.community.state.ia.us.

b. Applications shall be submitted by the deadline established by IDED.

c. IDED shall review applications and make funding decisions based on the following criteria:

(1) Magnitude of need for the project.

(2) Impact of the activity on standard of living or quality of life of proposed beneficiaries.

(3) Readiness to proceed with the proposed activity and likelihood that the activity can be completed in a timely fashion. Procurement of an engineer shall be considered evidence of readiness to proceed.

(4) Degree to which water and sewer fund assistance would be leveraged by other funding sources and documentation of applicant efforts to secure the maximum amount possible of local financial support for the activity.

(5) Capacity to operate and maintain the proposed activity.

(6) Capacity for continued viability of the activity after CDBG assistance.

(7) Scope of project benefit relative to the amount of CDBG funds invested.

(8) Degree to which the project promotes orderly, compact development supported by affordable public infrastructure.

d. Applicants shall submit preliminary engineering reports with their full applications for drinking water projects.

e. Applicants shall submit facility plans with their full applications for wastewater projects.

f. IDED staff may consult on proposed activities with other state agencies responsible for water- and sewer-related activities and may conduct site evaluations of proposed activities.

g. Applicants selected to receive awards shall be notified by letter from the IDED director by date(s) determined by IDED.

23.6(4) *Community facilities and services fund application procedure.* Each year, IDED shall announce the availability of funds and instructions for applying for funds through direct mail, public notices, media releases, workshops or other means determined necessary by IDED.

a. Application forms shall be available upon request from IDED, Community Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309, or on the division's Web site at www.community.state.ia.us.

b. Applications shall be submitted by the deadline established by IDED.

c. IDED shall review applications and make funding decisions based on the following criteria:

(1) Magnitude of need for the project.

(2) Impact of the activity on standard of living or quality of life of proposed beneficiaries.

(3) Readiness to proceed with the proposed activity and likelihood that the activity can be completed in a timely fashion.

(4) Degree to which community facilities and services fund assistance would be leveraged by other funding sources and documentation of applicant efforts to secure the maximum amount possible of local financial support for the activity.

(5) Capacity to operate and maintain the proposed activity.

(6) Capacity for continued viability of the activity after CDBG assistance.

(7) Scope of project benefit relative to the amount of CDBG funds invested.

(8) Degree to which the project promotes orderly, compact development supported by affordable public infrastructure.

(9) Whether the project meets or exceeds the minimum building and site design criteria established by IDED to be eligible for funding.

d. IDED staff may consult on proposed activities with other state agencies responsible for community facilities and services-related activities and may conduct site evaluations of proposed activities.

e. Applicants selected to receive awards shall be notified by letter from the IDED director by date(s) determined by IDED.

23.6(5) *Contingent funding.* IDED may make awards contingent upon receipt of funding from other sources.

23.6(6) *Negotiation of awards.* IDED reserves the right to negotiate award amounts and terms.

261—23.7(15) Requirements for the economic development set-aside fund.

23.7(1) *Restrictions on applicants.*

a. Applicants shall apply only for direct loans or forgivable loans to make to private businesses for the creation of new jobs or the retention of existing jobs that would otherwise be lost.

b. The maximum grant award for individual business assistance applications from any city or county is $1,000,000.

c. To be eligible for assistance, applicants shall meet the qualifying wage threshold requirements described in 261—Chapter 174.

d. At least 51 percent of the permanent jobs created or retained by the proposed project shall be taken by or made available through first consideration activities to persons from low- and moderate-income families.

e. Projects must maintain a minimum ratio of one permanent job created or retained for every $10,000 in CDBG funds awarded.

f. Terms of conventional loans proposed for the project must be consistent with terms generally accepted by conventional financial institutions.

g. Applications must provide evidence of adequate private equity.

h. Applications must provide evidence that the EDSA funds requested are necessary to make the proposed project feasible and that the business requesting assistance can continue as a going concern in the foreseeable future if assistance is provided.

i. IDED shall not consider applications proposing business relocation from within the state unless evidence exists of unusual circumstances that make the relocation necessary for the business' viability.

j. No significant negative land use or environmental impacts shall occur as a result of the project.

k. Rescinded IAB 10/22/08, effective 11/26/08.

l. Unless in conflict with a federal HUD definition for CDBG, the standard definitions located in 261—Chapter 173 apply to the EDSA program.

23.7(2) *Application procedure.* Application forms and instructions shall be available upon request from IDED, Business Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309; telephone (515)242-4819. An original and two copies of completed applications with required attachments shall be submitted to the same address. IDED shall accept EDSA applications at any time and shall review applications on a continuous basis. IDED shall take action on submitted applications within 60 days of receipt. Action may include funding the application for all or part of the requested amount, denying the applicant's request for funding or requesting additional information from the applicant for consideration before a final decision is made.

23.7(3) *Review criteria.* IDED shall review applications and make funding decisions based on the following criteria:

1. Impact of the project on the community.
2. Appropriateness of the jobs to be created or retained by the proposed project.
3. Appropriateness of the proposed wage and benefit package available to employees in jobs created or retained by the proposed project.
4. Degree to which EDSA funding would be leveraged by private investment.
5. Degree of demonstrated business need.

In evaluating applications, IDED shall give supplementary credit to applicants who have executed a good neighbor agreement with the business to be assisted.

IDED may conduct site evaluations of proposed projects.

261—23.8(15) Requirements for the public facilities set-aside fund. PFSA funds are reserved for infrastructure projects in direct support of economic development activities that shall create or retain jobs.

23.8(1) *Restrictions on applicants.*

a. The maximum grant award for individual applications is $500,000.

b. At least 51 percent of the permanent jobs created or retained by the proposed project shall be taken by or made available through first consideration activities to persons from low- and moderate-income families.

c. Projects must maintain a minimum ratio of one permanent job created or retained for every $10,000 in CDBG funds awarded.

d. The applicant local government must contribute at least 50 percent of the total amount of funds requested.

e. Applications must provide evidence that the PFSA funds requested are necessary to make the proposed project feasible and that the business requesting assistance can continue as a going concern in the foreseeable future if assistance is provided.

f. Jobs created as a result of other jobs being displaced elsewhere in the state shall not be considered to be new jobs created.

g. No significant negative land use or environmental impacts shall occur as a result of the project.

h. Applications shall include a business assessment plan, projecting for each identified business the number of jobs to be created or retained as a result of the public improvement proposed for assistance.

23.8(2) *Application procedure.* Application forms and instructions shall be available upon request from IDED, Business Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309; telephone (515)242-4819. An original and one copy of completed applications with required attachments shall be submitted to the same address. IDED shall accept PFSA applications at any time and shall review applications on a continuous basis. IDED shall take action on submitted applications within 60 days of receipt. Action may include funding the application for all or part of the requested amount, denying the applicant's request for funding or requesting additional information from the applicant for consideration before a final decision is made.

23.8(3) *Review criteria.* IDED shall review applications and make funding decisions based on the following criteria:

1. Impact of the project on the community.
2. Number of jobs created or retained per funds requested.
3. Degree to which PFSA funding would be leveraged by private investment.
4. Degree of demonstrated need for the assistance.

IDED may conduct site evaluations of proposed projects.

261—23.9(15) Requirements for the career link program. Projects funded through the career link program assist the unemployed and underemployed to obtain the training and skills necessary to move into available higher-skill, higher-paying jobs.

23.9(1) *Restrictions on applicants.*

a. Identified positions shall pay an average starting wage that meets or exceeds the lower of 100 percent of the average county wage or 100 percent of the average regional wage.

b. Applications shall include evidence of business participation in the curriculum design and evidence that a number of positions are available equal to or greater than the number of persons to be trained.

c. The project length shall not exceed 24 months.

d. Applicants may use awarded funds for training, transportation and child care costs. Up to 5 percent of funds may be used for administration.

e. Rescinded IAB 1/19/05, effective 2/23/05.

23.9(2) *Application procedure.* Application forms and instructions shall be available upon request from IDED, Community Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309; telephone (515)242-4783. An original and five copies of completed applications shall be submitted to the same address. IDED shall accept career link applications at any time and shall review applications on a continuous basis until all program funds are obligated or the program is discontinued.

23.9(3) *Review criteria.* IDED shall review applications and make funding decisions based on the following criteria:

1. Quality of the jobs available and business participation.
2. Merit of the proposed training plan.
3. Degree to which career link funds are leveraged by other funding sources.
4. Merit of the recruitment/job matching plan.
5. Scope of project benefit relative to the amount of funds invested.

261—23.10(15) Requirements for the contingency fund. The contingency fund is reserved for communities experiencing a threat to public health, safety or welfare that necessitates immediate corrective action sooner than can be accomplished through normal community development block grant procedures, or for disaster recovery activities, or for communities developing a sustainable community demonstration project.

23.10(1) *Application procedure.* Those local governments applying for contingency funds shall submit a written request to IDED, Community Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309. The request shall include a description of the situation, the project budget including the amount of the request from IDED, projected use of funds and an explanation of the reason that the situation cannot be remedied through normal CDBG funding procedures.

23.10(2) *Application review.* Upon receipt of a request for contingency funding, IDED shall determine whether the project is eligible for funding and notify the applicant of its determination. A project shall be considered eligible if it meets the following criteria:

a. Projects to address a threat to health and safety.

(1) An immediate threat to health, safety or community welfare must exist that requires immediate action.

(2) The threat must be the result of unforeseeable and unavoidable circumstances or events.

(3) No known alternative project or action would be more feasible than the proposed project.

(4) Sufficient other local, state or federal funds either are not available or cannot be obtained in the time frame required.

b. Projects to demonstrate sustainable community activities.

(1) The project is consistent with sustainability and smart growth principles.

(2) The project provides a beneficial impact on the standard of living and quality of life of proposed beneficiaries.

(3) The project can be ready to proceed and be completed in a timely manner.

(4) The project leverages the maximum amount of local funds possible.

(5) The project will continue to remain viable after CDBG assistance.

(6) The project meets the funding standards established by the funding criteria set forth in this rule.

(7) The applicant provides adequate information to IDED on total project design and costs as requested.

(8) The project is innovative and could be replicated in other communities.

(9) The project meets or exceeds the minimum building and site design criteria established by IDED.

23.10(3) *Additional information.* IDED reserves the right to request additional information on forms prescribed by IDED prior to making a final funding decision. IDED reserves the right to negotiate final project award and design components.

23.10(4) *Future allocations.* IDED reserves the right to reserve future funds anticipated from federal CDBG allocations to the contingency fund to offset current need for commitment of funds which may be met by amounts deferred from current awards.

261—23.11(15) Requirements for the housing fund program. Specific requirements for the housing fund are listed separately at 261—Chapter 25.

261—23.12(15) Interim financing program. The objective of the CDBG interim financing program is to benefit persons living in eligible Iowa communities by providing short-term financing for the implementation of projects that create or retain employment opportunities, prevent or eliminate blight or accomplish other federal and state community development objectives. Up to $25 million shall be made available for grants under the CDBG interim financing program during any program year.

23.12(1) *Eligible activities.* Funds provided through the interim financing program shall be used for the following activities:

1. Short-term assistance, interim financing or construction financing for the construction or improvement of a public work.

2. Short-term assistance, interim financing or construction financing for the purchase, construction, rehabilitation or other improvement of land, buildings, facilities, machinery and equipment, fixtures and appurtenances or other projects undertaken by a for-profit organization or business or a nonprofit organization.

3. Short-term or interim financing assistance for otherwise eligible projects or programs.

23.12(2) *Restrictions on applicants.*

a. No significant negative land use or environmental impacts shall occur as a result of the project.

b. Applications must provide evidence that the proposed project shall be completed within 30 months of the date of grant award.

c. The amount of funds requested shall not exceed $20 million.

d. Applications must provide evidence of an irrevocable letter of credit or equivalent security instrument from an AA- or better-rated lending institution, assignable to IDED, in an amount equal to the CDBG short-term grant funds requested, plus interest, if applicable.

e. Applications must provide evidence of the commitment of permanent financing for the project.

f. Applications must include assurance that program income earned or received as a result of the project shall be returned to IDED on or before the end date of the grant contract.

23.12(3) *Application procedure.* Applications may be submitted at any time in a format prescribed by IDED. Applications shall be processed, reviewed and considered on a first-come, first-served basis to the extent funds are available. IDED shall make funding decisions within 30 days of a receipt of a completed application. Applications that are incomplete or require additional information, investigation or extended negotiation may lose funding priority.

23.12(4) *Application review.* Applications shall be reviewed and funding decisions made based on the following review criteria:

1. Degree to which CDBG funds would be leveraged by other funding sources.
2. Reasonableness of the project cost per beneficiary ratio.
3. Documented need for the CDBG assistance.

4. Degree of public benefit, as measured by the present value of proposed assistance to direct wages and aggregate payroll lost, indirect wages and aggregate payroll lost, dislocation and potential absorption of workers and the loss of economic activity.

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

261—23.14(15) Disaster recovery fund. The disaster recovery fund is reserved for communities impacted by natural disasters when a supplemental disaster appropriation is made under the community development block grant program. Funds are available to repair damage and to prevent future threat to public health, safety or welfare that is directly related to the disaster for which HUD supplemental funds have been allocated to the state.

23.14(1) *Application procedure.* Communities in need of disaster recovery funds shall submit a written request to IDED, Community Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309. The request shall include a description of the community's problem, the amount of funding requested, projected use of funds, the amount of local funds to be provided and the percent of low- and moderate-income persons benefiting from the project.

23.14(2) *Application review.* Upon receipt of a request, IDED, in consultation with appropriate federal, state and local agencies, shall make a determination of whether the community and project are eligible for funding and notify the applicant community of its determination. A project shall be considered eligible only if it meets all of the following criteria:

1. A threat must exist to health, safety or community welfare that requires immediate action.
2. The threat must be a result of a natural disaster receiving a presidential declaration for which IDED received a supplemental HUD appropriation.
3. No known alternative project or action would be more feasible than the proposed project.
4. Sufficient other local, state or federal funds (including the CDBG competitive program) either are not available or cannot be obtained in the time frame required.

23.14(3) *Compliance with federal and state regulation.* A community receiving funds under the disaster recovery fund shall comply with all laws, rules and regulations applicable to the CDBG competitive program, except those waived by HUD as a result of federal action in conjunction with the disaster recovery initiative and those not required by federal law that IDED may choose to waive. IDED shall make available a list of all applicable federal regulations and disaster-related waivers granted by Congress and relevant federal agencies to all applicants for assistance.

261—23.15(15) Administration of a CDBG award. This rule applies to all grant recipients awarded funds from any of the CDBG programs. Recipients shall comply with requirements and instructions set forth in the applicable CDBG management guide.

23.15(1) *Contracts.* After making an award notification to a recipient, IDED will issue a CDBG contract. The contract shall be between the recipient local government and IDED. These rules and applicable federal and state laws and regulations shall be part of the contract.

a. Recipients shall execute and return the contract to IDED within 45 days of the transmittal date from IDED. Failure to do so may be cause for termination of the award.

b. Certain activities require permits or clearances that shall be obtained from other state or federal agencies prior to proceeding with the project. IDED may include securing necessary permits or clearances as conditions to the CDBG contract.

23.15(2) *General financial management standards.* Recipients shall comply with 24 CFR 85, as revised January 1, 2007, Administrative Requirements for Grants and Cooperative Agreements to State, Local and Federally Recognized Indian Tribal Governments. Allowable costs shall be determined in accordance with OMB Circular A-87, "Cost Principles Applicable to Grants and Contracts with State and Local Governments."

23.15(3) *Requests for funds.* Recipients shall submit requests for funds in the manner described and on the forms provided in the CDBG management guide. Individual requests for funds shall be made in whole dollar amounts not less than $500, except for the final request for funds.

23.15(4) *Program income.* If a recipient receives program income before the contract end date, it must be expended before requesting additional funds. If a recipient receives program income on or after the contract end date, the recipient may reuse the program income according to an IDED-approved reuse plan, or the recipient may return the program income to IDED. If a recipient receives less than $25,000 of program income cumulative of all CDBG grants in a program year, it shall be considered miscellaneous revenue and may be used for any purpose.

23.15(5) *Record keeping and retention.* All records related to the project, including the original grant application, reports, financial records and documentation of compliance with state and federal requirements, shall be retained for five years after contract closeout. Representatives of HUD, the Inspector General, the General Accounting Office, the state auditor's office and IDED shall have access to all books, accounts, documents, records and other property belonging to or in use by recipients pertaining to the receipt of CDBG funds.

23.15(6) *Performance reports and reviews.* Recipients shall submit recipient performance reports to IDED as prescribed in the CDBG management guide. IDED shall perform project reviews and site inspections deemed necessary to ensure program compliance. When noncompliance is indicated, IDED may require remedial actions to be taken.

23.15(7) *Contract amendments.* Any substantive change to a funded CDBG project, including time extensions, budget revisions and significant alteration to proposed activities, shall be considered a contract amendment. The recipient shall request the amendment in writing. No amendment shall be valid until approved in writing by IDED. IDED shall not approve the addition of a new activity unrelated to the original contract activities, unless all original activities shall also be completed per the contract. In such cases, IDED may allow up to $10,000 of the original CDBG award to be used for a new activity. For projects funded under the economic development set-aside, IDED shall not approve amendments involving the replacement of one activity with another.

23.15(8) *Contract closeout and audit.* Upon completion of project activities and contract expiration, IDED shall initiate closeout procedures. Contracts may be subject to audit before closeout of the contract can be completed. Recipients that expend $500,000 or more of federal funds within one year must have these funds audited. The audit shall be performed in a manner consistent with the provisions set forth in the Single Audit Act, as revised in 1996, and described in the CDBG management guide.

23.15(9) *Contractors and subrecipients limitation.* CDBG funds shall not be used directly or indirectly to employ, award contracts to, otherwise engage the services of or fund any contractor or subrecipient during any period of debarment, suspension or placement in ineligibility status by HUD under the provisions of 24 CFR 24, as revised April 1, 1997.

23.15(10) *Compliance with federal and state laws and regulations.* Recipients shall comply with all applicable provisions of the Housing and Community Development Act of 1974 and these administrative rules. Recipients shall also comply with any provisions of the Iowa Code governing activities performed under this program.

23.15(11) *Noncompliance.* At any time before project closeout, IDED may, for cause, find that a recipient is not in compliance with requirements under this program. At IDED's discretion, remedies for noncompliance may include penalties up to and including the return of program funds to IDED. Findings of noncompliance may include the use of CDBG funds for activities not described in the application, failure to complete approved activities in a timely manner, failure to comply with any applicable state or federal rules or regulations or the lack of a continuing capacity of the recipient to carry out the approved project in a timely manner.

23.15(12) *Appeals process for findings of noncompliance.* Appeals shall be entertained in instances where it is alleged that IDED staff participated in a decision that was unreasonable, arbitrary, capricious or otherwise beyond the authority delegated to IDED. Appeals shall be addressed to the division administrator of the community development division. Appeals shall be in writing and submitted to IDED within 15 days of receipt of the finding of noncompliance. The appeal shall include reasons why the decision should be reconsidered. The director shall make the final decision on all appeals.

261—23.16(15) Requirements for the downtown revitalization fund. Downtown revitalization funds are reserved for eligible CDBG activities that assist in the revitalization of downtown areas.

23.16(1) *Maximum grant award.* The maximum grant award for individual applications is $500,000.

23.16(2) *Application procedure.* Application forms and instructions shall be available upon request from IDED, Community Development Division, 200 East Grand Avenue, Des Moines, Iowa 50309, or on the division Web site at www.iowalifechanging.com/community.

23.16(3) *Review criteria.* IDED shall review applications and make funding decisions based on the following criteria:

a. Impact of the project on the community.

b. Readiness to proceed with the proposed activity and likelihood that the activity can be completed in a timely fashion.

c. Level of community support for a downtown revitalization effort.

d. Degree to which downtown revitalization fund assistance would be leveraged by other funding sources and documentation of applicant efforts to secure the maximum amount of local financial support for the activity.

e. Degree to which the activity meets or exceeds the minimum building and site design criteria established by IDED to be eligible for funding.

f. Level of planning completed for comprehensive downtown revitalization efforts.

These rules are intended to implement Iowa Code section 15.108(1)*"a."*

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[1] See IAB Economic Development Department.

CHAPTER 36
FILM, TELEVISION, AND VIDEO PROJECT PROMOTION PROGRAM

261—36.1(15) Purpose. The purpose of the film, television, and video project promotion program is to assist and encourage the production of legitimate film, television, and video projects within the state of Iowa.

261—36.2(15) Definitions. The following definitions apply to this chapter:

"Act" means Iowa Code sections 15.391 to 15.393 as amended by 2009 Iowa Acts, Senate File 480, that authorize tax credits for film, television, and video projects.

"Commercial domicile" means the principal place from which the trade of business of the taxpayer is directed or managed.

"IDED" means the Iowa department of economic development.

"Investor" means a person or entity that participates financially in a film, television, or video project that is registered by IDED.

"Iowa-based business" means a business whose commercial domicile is in Iowa.

"Producer" or *"production company"* means the legally designated entity that undertakes and pays for the project activities in Iowa.

"Project" means a film, television, or video production operation that involves expenditures and is undertaken in Iowa during the period of time defined in the application.

"Registered" or *"registered project"* means a film, television, or video production operation that has been determined by IDED to meet the criteria in 261—36.3(15).

[**ARC 7956B**, IAB 7/15/09, effective 7/1/09]

261—36.3(15) Request for registration of a film, television, or video project. To be eligible to receive tax credits under this program, a request for registration shall be submitted to IDED. Requests for registration of projects must be received in accordance with deadlines posted by the department. The Iowa film office at IDED will specify the form and content of the requests, which, at a minimum, shall document that the project:

36.3(1) Is a legitimate effort to produce an entire film, television, or video episode or a film, television, or video segment in the state.

36.3(2) Will include expenditures of at least $100,000 in the state and have an economic impact on the economy of the state or locality sufficient to justify assistance under the program.

36.3(3) Will further tourism, economic development, and population retention or growth in the state or locality.

36.3(4) Is intended to be widely distributed beyond the Midwest region.

36.3(5) Will not depict or describe any obscene material, as defined in Iowa Code section 728.1.

36.3(6) Has commitments for at least 50 percent of the funding.

36.3(7) The department may charge a nonrefundable fee for registration of a project under the program. The fee shall be paid to the department. The amount of the fee shall equal 1/8 of 1 percent of the value of the tax credit, and 1/16 of 1 percent of the estimated credit value shall be paid upon confirmation of the project's eligibility to contract with the state under the program. The remaining balance shall be paid upon calculation of the total project qualified spending. Registration fees collected by the department under this subrule shall be used to support industry training, to sponsor industry events and to market the program. One-half of the fees collected will be used for industry training, 25 percent of the fees collected will be used to sponsor industry events and 25 percent of the fees collected will be used to market the program.

[**ARC 7956B**, IAB 7/15/09, effective 7/1/09]

261—36.4(15) IDED list of registered film, television, or video projects.

36.4(1) Upon review of the information provided in an applicant's request for registration, if the request meets the criteria listed in rule 261—36.3(15), IDED will include the project on IDED's list of registered film, television, or video projects.

36.4(2) Projects included on IDED's list of registered film, television, or video projects will be eligible for the tax credits authorized by the Act, determined by the department and stipulated in the project contract.
[**ARC 7956B**, IAB 7/15/09, effective 7/1/09]

261—36.5(15) Contract administration.

36.5(1) *Notice of approval.* Successful applicants will be notified in writing of approval of a request for registration, including any conditions and terms of the approval.

36.5(2) *Contract required.* The department shall prepare a contract, which includes, but is not limited to, a description of the project to be completed by the business; terms and conditions for receipt of tax credit benefits; the amount of the tax credit and the repayment requirements or other penalties imposed in the event the recipient does not fulfill its obligations described in the contract.

36.5(3) *Contract amendments.* Projects approved under this program are limited to the descriptions and criteria stated on the application. Changes to a registered project must be reported in writing immediately to the Iowa film office along with a request for contract amendment. Upon review, the department will approve or deny the request for amendment. If the request is approved, a written contract amendment will be executed by the recipient and the department.

36.5(4) *Default.* Failure to complete the registered project in compliance with the descriptions and terms established in the application shall constitute a default and result in loss of tax credit benefits.
[**ARC 7956B**, IAB 7/15/09, effective 7/1/09]

261—36.6(15) Benefits available. Approved projects are eligible to claim the following tax credit benefits:

1. Qualified expenditure tax credit.
2. Qualified investment tax credit.

261—36.7(15) Qualified expenditure tax credit.

36.7(1) *Description.*

a. For tax years beginning on or after January 1, 2007, a qualified expenditure tax credit shall be allowed against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24, for a portion of a taxpayer's qualified expenditures in a project registered under the program.

b. The tax credit shall not exceed 25 percent of the qualified expenditures on a project. The department may negotiate the amount of the tax credit.

c. Under rule 261—36.7(15), an individual may claim a tax credit of a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings from the partnership, limited liability company, S corporation, estate, or trust.

d. Any tax credit in excess of the taxpayer's liability for the tax year may be credited to the tax liability for the following five years or until depleted, whichever is earlier.

e. A tax credit shall not be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit.

36.7(2) *Qualified expenditures.*

a. A qualified expenditure by a taxpayer is a payment to an Iowa resident or an Iowa-based business for the sale, rental, or furnishing of tangible personal property or for services directly related to the registered project including, but not limited to:

1. Aircraft.
2. Vehicles.
3. Equipment.
4. Materials.
5. Supplies.
6. Accounting.
7. Animals and animal care.

8. Artistic and design services.
9. Graphics.
10. Construction.
11. Data and information services.
12. Delivery and pickup services.
13. Labor and personnel as described in 36.7(2)*"b."*
14. Lighting.
15. Makeup and hairdressing.
16. Film.
17. Music.
18. Photography.
19. Sound.
20. Video and related services.
21. Printing.
22. Research.
23. Site fees and rental.
24. Travel related to Iowa distant locations.
25. Trash removal and cleanup.
26. Wardrobe.

b. Labor and personnel. For purposes of this subrule, "labor and personnel" includes the following:

(1) Compensation that is paid to the principal producer, principal director, and principal cast members is a qualified expenditure if the principal producer, principal director, or principal cast member is an Iowa resident or an Iowa-based business and if the compensation paid meets one of the following conditions:

1. If the total of qualified expenditures is at least $10 million but less than $20 million, the qualifying compensation paid to each principal producer, principal director, and principal cast member shall not exceed $250,000 each.

2. If the total of qualified expenditures is at least $20 million, the qualifying compensation paid to each principal producer, principal director, and principal cast member shall not exceed $1 million each.

(2) Compensation that is paid to personnel other than the principal producer, principal director, or principal cast members qualifies if the compensation meets one of the following conditions:

1. If the total of qualified expenditures is less than $10 million, the qualifying compensation paid to labor and personnel other than the principal producer, the principal director, and principal cast members shall not exceed $150,000 for each detailed budget line item or for each budget accounting subcode.

2. If the total of qualified expenditures is at least $10 million but less than $20 million, the qualifying compensation paid to labor and personnel other than the principal producer, the principal director, and the principal cast members shall not exceed $200,000 for each detailed budget line item or for each budget accounting subcode.

3. If the total of qualified expenditures is at least $20 million, the qualifying compensation paid to labor and personnel other than the principal producer, the principal director, and the principal cast members shall not exceed $300,000 for each detailed budget line item or for each budget accounting subcode.

c. The department and the department of revenue shall establish a list of eligible expenditures and negotiable expenditures.

36.7(3) *Approval of tax credit—process.*

a. After project completion and verification of the eligibility for a tax credit under this program, IDED shall issue a film, television, and video project promotion program tax credit certificate to be attached to the taxpayer's tax return.

b. The tax credit certificate shall contain the taxpayer's name, address, tax identification number, the date of project completion, the amount of credit, other information required by the department of

revenue, and a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred.

c. A tax credit certificate issued may be transferred to any person or entity. Within 90 days of transfer, the transferee shall submit the transferred tax credit certificate to the department of revenue along with a statement containing the transferee's name, tax identification number, and address, and the denomination that each replacement tax credit certificate is to carry and any other information required by the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the transferee's statement, the department of revenue shall issue one or more replacement tax credit certificates to the transferee. Each replacement tax credit certificate must contain the information required for the original tax credit certificate and must have the same expiration date that appeared in the transferred tax credit certificate. Any certificates issued on or after the program's effective date, May 17, 2007, may be freely transferred without regard to face value. A maximum of two transfers shall be allowed.

d. A qualified expenditure tax credit shall not be claimed by a transferee until a replacement tax credit certificate identifying the transferee as the proper holder has been issued.

e. The transferee may use the amount of the tax credit transferred against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24, for any tax year the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included as income under Iowa Code chapter 422, divisions II, III, and V, under Iowa Code chapter 432, or against the moneys and credits tax imposed in Iowa Code section 533.24. Any consideration paid for the transfer of the tax credit shall not be deducted from income under Iowa Code chapter 422, divisions II, III, and V, under Iowa Code chapter 432, or against the moneys and credits tax imposed in Iowa Code section 533.24.

36.7(4) *Approval of tax credit—reporting.* All qualified expenditures made for a registered project must be submitted in a format approved by the department prior to production once the producer has completed the project. No additional claims will be accepted once the Schedule of Qualified Expenses or previously approved documentation has been received by the Iowa film office.
[**ARC 7956B**, IAB 7/15/09, effective 7/1/09]

261—36.8(15) Qualified investment tax credit.

36.8(1) *Description.*

a. For tax years beginning on or after January 1, 2007, an investment tax credit shall be allowed against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24, for a portion of a taxpayer's investment in a project registered under the program.

b. The tax credit shall not exceed 25 percent of the investment in the project. Under rule 261—36.8(15), an individual may claim a tax credit of a partnership, limited liability company, S corporation, estate, or trust electing to have income taxed directly to the individual. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings from the partnership, limited liability company, S corporation, estate, or trust.

c. Any tax credit in excess of the taxpayer's liability for the tax year may be credited to the tax liability for the following five years or until depleted, whichever is earlier.

d. A tax credit shall not be carried back to a tax year prior to the tax year in which the taxpayer claims the tax credit.

36.8(2) *Approval of tax credit—process.*

a. After project completion and verification of the eligibility for a tax credit under this program, the Iowa department of economic development shall issue a film, television, and video project promotion program tax credit certificate to be attached to the taxpayer's tax return.

b. The tax credit certificate shall contain the taxpayer's name, address, tax identification number, the date of project completion, the amount of credit, other information required by the department of

revenue, and a place for the name and tax identification number of a transferee and the amount of the tax credit being transferred.

c. A tax credit certificate issued may be transferred to any person or entity. Within 90 days of transfer, the transferee shall submit the transferred tax credit certificate to the department of revenue along with a statement containing the transferee's name, tax identification number, and address, and the denomination that each replacement tax credit certificate is to carry and any other information required by the department of revenue. Within 30 days of receiving the transferred tax credit certificate and the transferee's statement, the department of revenue shall issue one or more replacement tax credit certificates to the transferee. Each replacement tax credit certificate must contain the information required for the original tax credit certificate and must have the same expiration date that appeared in the transferred tax credit certificate. Any certificates issued on or after the program's effective date, May 17, 2007, may be freely transferred without regard to face value. A maximum of two transfers shall be allowed.

d. An investment tax credit shall not be claimed by a transferee until a replacement tax credit certificate identifying the transferee as the proper holder has been issued.

e. The transferee may use the amount of the tax credit transferred against the taxes imposed in Iowa Code chapter 422, divisions II, III, and V, and in Iowa Code chapter 432, and against the moneys and credits tax imposed in Iowa Code section 533.24, for any tax year the original transferor could have claimed the tax credit. Any consideration received for the transfer of the tax credit shall not be included as income under Iowa Code chapter 422, divisions II, III, and V, under Iowa Code chapter 432, or against the moneys and credits tax imposed in Iowa Code section 533.24. Any consideration paid for the transfer of the tax credit shall not be deducted from income under Iowa Code chapter 422, divisions II, III, and V, under Iowa Code chapter 432, or against the moneys and credits tax imposed in Iowa Code section 533.24.

36.8(3) *Limitation.* The same taxpayer cannot claim both an expenditure tax credit and an investment tax credit on the same project.

36.8(4) *Calculation.* The total of all investment tax credits per project cannot exceed 25 percent of qualified expenditures on that project. This amount will be awarded proportionally to each individual's investment in the registered project.

[**ARC 7956B**, IAB 7/15/09, effective 7/1/09]

261—36.9(15) Reduction of gross income due to payments received from qualified expenditures in registered projects.

36.9(1) For the tax year in which a qualified expenditure occurred, and for the ensuing three tax years, a taxpayer may claim a reduction in adjusted gross income not to exceed in a tax year 25 percent of the amount of the qualified expenditure for purposes of taxes imposed in Iowa Code chapter 422, divisions II and III, for payments received from the sale, rental, or furnishing of tangible personal property or services directly related to the production of a project registered under this chapter which meets the criteria of a qualified expenditure under rule 261—36.7(15).

36.9(2) A taxpayer claiming a qualified expenditure tax credit, a business in which such taxpayer has an equity interest, or a business in whose management such taxpayer participates is not eligible to receive the adjusted gross income reduction under this rule.

[**ARC 7956B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code sections 15.391 to 15.393 as amended by 2009 Iowa Acts, Senate File 480.

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CHAPTER 53
COMMUNITY ECONOMIC BETTERMENT ACCOUNT (CEBA) PROGRAM

[Prior to 1/14/87, Iowa Development Commission[520] Ch 8]
[Prior to 7/19/95, see 261—Ch 22]
[Former Ch 53, "Economic and Research and Development Grants," rescinded IAB 7/19/95, effective 8/23/95]

261—53.1(15) Purpose and administrative procedures.

53.1(1) *Purpose.* The purpose of the community economic betterment account (CEBA) program is to assist communities and rural areas of the state with their economic development efforts and to increase employment opportunities for Iowans by increasing the level of economic activity and development within the state. The program structure provides financial assistance to businesses and industries which require assistance in order to create new job opportunities or retain existing jobs which are in jeopardy. Also, the program may provide comprehensive management assistance to businesses involved with the CEBA program. Assistance may be provided to encourage:

1. New business start-ups in Iowa;
2. Expansion of existing businesses in Iowa; or
3. The recruitment of out-of-state businesses into Iowa.

53.1(2) *Administrative procedures.* The CEBA program is subject to the requirements of the department's rules located in 261—Part VII, additional application requirements and procedures, and 261—Part VIII, legal and compliance.

261—53.2(15) Definitions. In addition to the standard definitions located in 261—Chapter 173, the following definitions apply to the CEBA program:

"Applicant" means a city, county, or merged area school which requests state financial assistance on behalf of a business or a local development organization.

"Base economic activities" means those business activities which result in a net increase in the production of goods or services within the state. This would occur if a majority of the company's products or services were new, were sold outside the state, or were sold within the state in place of items previously purchased outside the state.

"Business start-up" means a business which has not been in operation for more than two years prior to the date of the CEBA application.

"Buydown" means participation by the state in a conventional loan to an assisted business by lowering either the effective principal or interest of the loan.

"CEBA" refers to the community economic betterment account funded by Iowa Code section 15.32(2).

"Comprehensive management assistance" means provision of technical business assistance through the use of department staff or professional business services provided by a public or private organization.

"Entrepreneurial development" means the promotion of small business ownership through the provision of technical management expertise.

"Modernization project" means an economic activity that is performed by a business to retool or upgrade production equipment to meet contemporary technology standards and that results in improving existing employees' job skills to enhance competitiveness for future growth and development.

"New business opportunity" means an economic activity performed by a start-up or recruited business that meets the definition of subrule 53.9(1).

"New product development" means an economic activity performed by an existing Iowa business through expansion or diversification and meets the definition of subrule 53.9(1).

"Project" means the activity, or set of activities proposed by the recipient, resulting in accomplishing the goals of the CEBA program, and which will require state assistance to accomplish.

"Retail business" means a business whose operation consists predominantly of the purchase of a product for sale to the final user or consumer who would not be purchasing for resale.

"Service business" means a business which produces and sells a thing of value which is not a tangible product.

"Small business" refers to a business which meets the size criteria for a small business as defined by the U.S. Small Business Administration and as published from time to time in the Federal Register.

"Twenty-eight E agreement" or *"28E agreement"* means an intergovernmental agreement formed according to Iowa Code chapter 28E.

"Venture project" means an economic activity performed by a start-up company, early-stage company, or existing company developing a new product or new technology.

261—53.3(15) Board and committee. Rescinded IAB 7/4/07, effective 6/15/07.

261—53.4(15) Eligible applicants. Only cities, counties, and merged area schools are eligible to apply to the department for funding under this program. Applicants which are awarded funds will pass those funds on to the recipient or approved recipient's vendor.

261—53.5(15) Provision of assistance.

53.5(1) *Eligible projects.* Projects eligible for CEBA funding include, but are not limited to, the following:

1. Building construction or reconstruction;
2. Acquisition of land;
3. Equipment purchases;
4. Operating and maintenance expenses;
5. Clearance, demolition and removal of buildings to develop sites;
6. Infrastructure improvements directly related to new employment;
7. Road construction projects directly supporting and assisting economic development;
8. Funds for guaranteeing business loans made by commercial lenders; and
9. Technical management assistance for businesses that are applying for or have received CEBA funding.

53.5(2) *Forms of assistance.* Assistance for projects may be provided in any of the following forms:

1. Principal buydowns to reduce the principal of a business loan;
2. Interest buydowns to reduce the interest on a business loan;
3. Forgivable loans;
4. Loans and loan guarantees, including short-term (float) loans. Float loans may only be made for projects where the department obtains an irrevocable letter of credit from an acceptable financial institution on behalf of the company in an amount equal to or greater than the principal amount of the loan;
5. Equity-like investments;
6. Cost reimbursement for technical/professional management services.

261—53.6(15) Application for assistance. The requirements outlined in this rule are applicable to all CEBA program components, except applications under the venture project component. Refer to rule 261—53.10(15) for application requirements for venture projects.

53.6(1) *General policies.*

a. An applicant may submit as many different applications as it wishes at any time. However, if the department is reviewing two or more applications from the same applicant at the same time, it may ask the applicant to rank them in the order preferred by the applicant.

b. Only one applicant may apply for any given project.

c. No single project may be awarded more than $1 million unless at least two-thirds of the members of the board approve the award. However, this restriction will not apply after the first $10 million has been credited to the CEBA program in any given year. This restriction does not apply to the float loan described in 53.5(2)"4."

d. No single project may be awarded a forgivable loan of more than $500,000.

e. No single project may be awarded more than $500,000 unless all other applicable CEBA requirements and each of the following criteria is met:

(1) The business has not closed or substantially reduced its operation in one area of the state and relocated substantially the same operation in the community. This requirement does not prohibit a business from expanding its operation in the community if existing operations of a similar nature in the state are not closed or substantially reduced.

(2) The business must provide and pay at least 80 percent of the cost of a standard medical and dental insurance plan or its equivalent for all full-time employees working at the facility in which the new investment occurred.

(3) The business shall agree to pay a wage for new full-time jobs of at least 130 percent of the average county wage in the county in which the community is located. This requirement may be waived by the department in the case of a float loan described in 53.5(2)"4" if the net value of the award is determined by the department to be less than $500,000.

f. To be eligible for assistance, the business shall provide for a preference for hiring residents of the state or the economic development area, except for out-of-state employees offered a transfer to Iowa or the economic development area.

g. To be eligible for assistance, applicants shall meet the qualifying wage threshold requirements described in 261—Chapter 174 and the following:

(1) Fifty percent or more of the jobs to be created or retained shall have a starting wage that pays at least the qualifying wage threshold.

(2) The department may approve a project where the starting project wage is less than the average county wage or average regional wage under the following conditions:

1. The starting wage is associated with a training period which is of relatively short duration as documented by the business; and

2. The wages will exceed 100 percent of the average county wage or 100 percent of the average regional wage at the conclusion of the training period as documented by the business; and

3. CEBA funds will be released only at the conclusion of the training period when the average county or average regional wage is achieved.

53.6(2) *Ineligible applications.* The department will not rate and rank ineligible applications. An application may be ruled ineligible if:

a. It is submitted by an ineligible applicant, or

b. The project consists of a business relocation from within the state unless unusual circumstances exist which make the relocation necessary for the business's viability, or

c. CEBA funds comprise more than 50 percent of the project's financing, or

d. The CEBA application is not properly signed by the applicant and the business, or

e. The project fails to meet the qualifying wage threshold requirements under 261—Chapter 174, or

f. The business has a record of violations of the law over a period of time that tends to show a consistent pattern as described in 261—Chapter 172.

53.6(3) *Procedures.*

a. Applications may be submitted at any time.

b. Applications should be submitted to: Division of Business Development, Department of Economic Development, CEBA Program, 200 East Grand Avenue, Des Moines, Iowa 50309. Application forms and instructions are available at this address, on the department's Web site, or by calling (515)242-4819.

c. Application contents. Required contents of application will be described within the application package itself.

d. Each eligible application will be reviewed by the department. The department may request additional information from the applicant or the proposed recipient, or perform other activities to obtain needed information.

e. The department will rate and rank applications according to the criteria in rule 53.7(15). Additionally, for small business gap financing applications, the department will use rule 53.8(15). For new business opportunities and new product development applications, the department will

use rule 53.9(15). Applications shall be reviewed and approved following the process described in 261—Chapter 175.

53.6(4) *Emergency applications.* Rescinded IAB 7/4/07, effective 6/15/07.

261—53.7(15) Selection criteria. In ranking applications for funding submitted under the small business gap financing component, the new business opportunities component, and the new product development component, at least the following criteria shall be considered:

53.7(1) *Relating to local/business involvement:*

a. The proportion of local match to be provided as compared to the local resources.

b. The proportion of private contribution to be provided, including the involvement of financial institutions.

c. The need of the business for financial assistance from governmental sources. More points shall be awarded to a business for which the department determines that governmental assistance is most necessary to the success of the project.

d. The level of need of the political subdivision.

e. The impact of the proposed project on the economy of the political subdivision and the state.

f. The certification of a community builder program for the community.

g. The expected recapture of these funds.

53.7(2) *Relating to job creation/retention:*

a. The total number of jobs to be created or retained. When rating a project, the department shall only consider those positions which meet the qualifying wage threshold requirements defined in 261—Chapter 174.

b. The quality of jobs to be created. In rating the quality of the jobs, the department shall award more points to those jobs that have a higher wage scale, a lower turnover rate, are full-time, career-type positions, or have other related factors. Those applications that have average starting wage scales which are 10 percent or more below that of the average county wage or average regional wage shall be given an overall score of zero. Business start-ups shall be given a score of zero only if their wage scales are 20 percent or more below that of the average county wage or average regional wage.

53.7(3) *Relating to business activity* :

a. The size of the business receiving assistance. The department shall award more points to small businesses as defined by the U.S. Small Business Administration.

b. The potential for future growth in the industry represented by the business being considered for assistance.

c. The impact of the proposed project on competitors of the business.

d. The capacity of the proposed project to create products by adding value to agricultural commodities.

e. The degree to which the proposed project relies upon agricultural or value-added research conducted at a college or university, including a regents institution, community college, or a private university or college.

261—53.8(15) Small business gap financing.

53.8(1) *Additional criteria.* Applications under this component shall be for businesses that meet the SBA definition of a small business. All geographic locations of the business will be used to determine the total number of employees. The criteria in rule 53.7(15) will be used for evaluating applications under this component.

53.8(2) *Application form.* Applicants applying for assistance under this component shall use the general business financial assistance application form provided by the department. The department may, at its option, transfer requests to a different financial assistance program, including but not limited to:

a. The new business opportunities or new product development components of CEBA;

b. EDSA (economic development set-aside program); or

c. PFSA (public facilities set-aside program).

53.8(3) *Scoring.* The criteria noted in rule 53.7(15) are incorporated into the scoring system as follows:

a. Local effort compared with local resources. Maximum — 20 points. This includes assistance from the city, county, community college, chambers of commerce, economic development groups, utilities, or other local sources, compared to the resources reasonably available from those sources. The form of local assistance compared to the form of CEBA assistance requested will be considered (e.g., in-kind, grant, loan, forgivable loan, job training, tax abatement, tax increment financing). The dollar amount of local effort and the timing of the local effort participation as compared to the dollar amount and timing of the requested CEBA participation will also be considered. Conventional financing, inadequately documented in-kind financing, and local infrastructure projects not specifically directed at the business are not considered local effort.

b. Community need. Maximum — 10 points. This includes considerations such as unemployment rates, per capita income, major closings and layoffs, declining tax base, etc.

c. Private contribution compared with CEBA request. Maximum — 30 points. The greater the contribution by the assisted business, the higher the score. Conventional financing will be considered a private contribution. Contribution in the form of "new cash equity" by the business owner will result in a higher score.

d. A project in a brownfield, blighted or distressed area or a business with a good neighbor agreement or an Iowa great places agreement, as described in 261—Chapter 171. Maximum — 10 points. Projects meeting these conditions will receive 10 points.

e. Extra points if small business, as defined by SBA. Maximum — 10 points.

f. Project impact on the state and local economy.

(1) Cost/benefit analysis. Maximum — 40 points. This factor compares the amount requested to the number of jobs to be created or retained as defined in paragraph 53.7(2)*"a"* and the projected increase in state and local tax revenues. Also considered here is the form of assistance (e.g., a forgivable loan will receive a lower score than a loan).

(2) Quality of jobs to be created. Maximum — 40 points. Higher points to be awarded for:

Higher wage rates;

Lower turnover rates;

Full-time, career-type positions;

Relative safety of the new jobs;

Health insurance benefits;

Fringe benefits;

Other related factors.

(3) Economic impact. Maximum — 40 points. Higher points to be awarded for base economic activities, e.g.:

Greater percentage of sales out of state, or import substitution;

Higher proportion of in-state suppliers;

Greater diversification of state economy;

Fewer in-state competitors;

Potential for future growth of industry;

Consistency with the state strategic plan for economic development prepared in compliance with Iowa Code section 15.104(2);

Increased value to agricultural commodities;

Degree of utilization of agricultural or value-added technology research from an Iowa educational institution;

A project which is not a retail operation;

A project which includes remediation or redevelopment of a brownfield site.

Maximum preliminary points for project impact — 120 points.

(4) Final impact score. Maximum — 120 points. Equal to preliminary impact score multiplied by a reliability factor (as a percent).

(NOTE OF EXPLANATION — Rating factors in 53.8(3)*"f"*(1) to (3) attempt to measure the expected impact of the project, if all predictions and projections in the application turn out to be accurate. Up to that point in the rating system, no attempt has been made to judge the feasibility of the business venture, the reliability of the job creation and financial estimates, the likelihood of success, the creditworthiness of the business, and whether the project would occur without state assistance. An attempt to analyze projects against these factors is also important. In order to incorporate this judgment into the rating system, the Preliminary Impact Score (Maximum of 120 points) is multiplied by a "reliability and feasibility factor" to obtain a final impact score, 53.8(3)*"f"*(4). This factor will range from 0 to 100 percent, depending upon the department's judgment as to the likelihood of the projections turning out as planned. If, in the department's judgment, the project would proceed whether it was funded or not, it will be assigned a zero percent on the reliability and feasibility factor and the final impact score will be zero. This is consistent with the intent of the program to use funds only where state assistance will make a difference.)

The maximum total score possible is 200 points.

Projects that score less than 120 points in rule 53.8(15) will not be recommended for funding by the staff to the committee.

53.8(4) *Project period.* Projects funded under rule 53.8(15) are considered to have a project period as described in 261—Chapter 187. This is the time period allowed for meeting and maintaining the job and performance obligations.

261—53.9(15) New business opportunities and new product development components.

53.9(1) *Additional criteria and targeting for new business opportunities and new product development components.* The criteria in rule 53.7(15) will be used for evaluating applications under these components. Applications for these components must be for businesses with projects that offer a quality economic opportunity to Iowans and meet one of the following characteristics:

a. The industry is one targeted within the state's strategic plan; or

b. The resulting economic activity is underrepresented in the state's overall economic activity mix.

53.9(2) *Applications.* Applicants applying for assistance under these components shall use the general business financial assistance application form provided by the department. The department may, at its option, transfer requests to a different financial assistance program, including but not limited to:

a. Small business gap financing component of CEBA;

b. EDSA (economic development set-aside program); or

c. PFSA (public facilities set-aside program).

53.9(3) *Rating system.* The rating system for proposed projects will be as follows:

a. Local effort (as defined in 53.8(3)*"a"*). Maximum — 20 points;

b. Private contributions as compared to CEBA request (as defined in 53.8(3)*"c"*). Maximum — 20 points;

c. A project in a brownfield, blighted or distressed area or a business with a good neighbor agreement or an Iowa great places agreement, as described in 261—Chapter 171. Maximum — 10 points. Projects meeting these conditions will receive 10 points;

d. Extra points if small business, as defined by the SBA. Maximum — 10 points;

e. Project impact, as defined in 53.8(3)*"f"* and 53.8(4). Maximum — 120 points;

f. Potential for future expansion of the industry in general. Maximum — 20 points. This factor awards additional points for those projects that tend to show a greater potential for expansion of that industry within Iowa.

The maximum total score possible is 200 points.

Projects that score less than 120 points in rule 53.9(15) will not be recommended for funding by the staff to the committee.

53.9(4) *Project period.* Projects funded under rule 53.9(15) are considered to have a project period as described in 261—Chapter 187. This is the time period allowed for meeting and maintaining the job and performance obligations.

261—53.10(15) Venture project components.

53.10(1) *Eligible applicants; projects; coordination with PROMISE JOBS.*

a. Eligible businesses. Eligible businesses include start-up companies, early-stage companies, and existing companies that are developing a new product or new technology.

b. Form and amount of assistance. The CEBA award will be in the form of an equitylike investment (e.g., royalty agreement or deferred loan). The maximum award amount shall not exceed $250,000.

c. Eligible applicants. Applications will be accepted from cities, counties, and community colleges on behalf of eligible businesses. Applications shall be submitted on the CEBA venture project application form provided by the department. If an application is approved, the department will contract directly with the business on whose behalf the application was submitted.

53.10(2) *Ineligible applications.* The department will not rate and rank ineligible applications. An application may be determined to be ineligible if:

a. It is submitted by an ineligible applicant; or

b. The project consists of a business relocation from within the state unless unusual circumstances exist which make the relocation necessary for the business's viability; or

c. The CEBA application is not properly signed by the applicant and the business; or

d. The business has a record of violations of the law over a period of time that tends to show a consistent pattern as described in 261—Chapter 172.

53.10(3) *Rating system.* Eligible applications will be reviewed and rated using the following criteria:

a. Jobs associated with the project. Factors considered include, but are not limited to, the following:

(1) The number of jobs created, if any, by the project;

(2) The potential for job creation as a result of the project;

(3) The quality of the wages and benefits for jobs actually or potentially created as a result of the project.

NOTE: For the venture project component, CEBA funds will not be leveraged on a per job basis. Maximum — 10 points.

b. Additional funding sources. The amount of the total project costs coming from sources other than CEBA venture funds including, but not limited to, private equity investment, conventional loans, owner equity investment, or other acceptable forms of investment as determined by the department. Maximum — 10 points.

c. Strength of the business plan. Factors to be considered include, but are not limited to, the following:

(1) A description of the business and the overall industry;

(2) The experience level of the business management team;

(3) A description of the product and production plan;

(4) Project financial projections;

(5) Feasibility of the product and project;

(6) Market identification and marketing strategy.

Maximum — 60 points.

d. Potential return on investment of the CEBA venture award. Maximum — 10 points.

e. Potential for future growth of the business. Maximum — 5 points.

f. Local financial support. The amount of the total project costs attributable to local funding sources including, but not limited to, city, county, community college, chamber of commerce, economic development groups, utilities, or other local sources, compared to the resources reasonably available from those sources. Maximum — 10 points.

g. A project in a brownfield, blighted or distressed area or a business with a good neighbor agreement or an Iowa great places agreement, as described in 261—Chapter 171 will receive 5 extra points.

Applications must receive a minimum of 60 points to be recommended for funding.

53.10(4) *Application review and approval.* Rescinded IAB 7/4/07, effective 6/15/07.

261—53.11(15) Modernization project component. The general program policies described in rule 261—53.6(15) are applicable to modernization projects. Exceptions to these general rules are identified in this rule. If there is a conflict between the general program policies and the modernization project component requirements as described in this rule, this rule will take priority. Applications must receive a minimum of 60 points to be recommended for funding.

53.11(1) *Additional criteria and targeting for modernization projects.* Modernization projects shall meet the following additional requirements:

a. Applications for this component must be for businesses with projects that offer a quality economic opportunity to Iowans.

b. The business shall demonstrate that it is modernizing and retooling to remain competitive.

c. The business shall demonstrate how employee job skills are being enhanced through advanced training and educational opportunities.

53.11(2) *Applications.* Businesses applying for assistance under this component shall use the general business financial assistance application form provided by the department. The department may, at its option, transfer requests to a different financial assistance program administered by the department.

53.11(3) *Project period.* Rescinded IAB 7/4/07, effective 6/15/07.

53.11(4) *Rating system.* Eligible applications will be reviewed and rated using the following criteria:

a. Strength of the business proposal. Factors to be considered include, but are not limited to, the following:

(1) Description of the business and the overall industry;

(2) Description and feasibility of the modernization project;

(3) Market identification and the business's current position in that market;

(4) Project financial history and projections;

(5) Total cost of the modernization project.

Maximum — 25 points.

b. Job positions associated with the project. Factors to be considered include, but are not limited to, the following:

(1) Increase in job skills as a result of the project as measured by job training and educational opportunities;

(2) Increased quality of the wages and benefits as a result of the project;

(3) Number of jobs impacted by the project.

NOTE: For the modernization project component, CEBA funds will not be leveraged on a per-job basis.

Maximum — 25 points.

c. Leverage of other additional funding sources. The amount of the total project costs coming from sources other than CEBA modernization funds including, but not limited to, private equity investment, conventional loans, owner equity investment, or other acceptable forms of investment as determined by the department. Maximum — 15 points.

d. Regional financial support. The amount of the total project costs attributable to regional funding sources including, but not limited to, city, county, community college, chamber of commerce, economic development groups, utilities, or other regional sources, compared to the resources reasonably available from those sources. Maximum — 15 points.

e. Potential for improved efficiency, capacity and competitiveness of the business. Maximum — 10 points.

f. Potential for future growth of the business and the industry. Maximum — 10 points.

53.11(5) *Application review and approval.* Rescinded IAB 7/4/07, effective 6/15/07.

261—53.12(15) Comprehensive management assistance and entrepreneurial development.

53.12(1) *Eligible applicants.* Application for comprehensive management assistance is limited to:

a. Businesses that have either previously received a CEBA award or have a CEBA application under current review by the department; or

b. Businesses requesting assistance in meeting the regulatory requirements of other government agencies.

53.12(2) *Use of funds.* Assistance is available only in the form of technical or professional assistance. This may be accomplished by use of department staff or department-contracted professional services in assisting the business to develop:

a. Entrepreneurial management skills;
b. Employment hiring, recruiting, or personnel assistance;
c. Inventory controls;
d. Financial controls;
e. Marketing plans; or
f. Other related business assistance.

53.12(3) *Determination of assistance.* Rescinded IAB 7/4/07, effective 6/15/07.

261—53.13(15) Award process. Rescinded IAB 7/4/07, effective 6/15/07.

261—53.14(15) Administration of projects—financial management. Rescinded IAB 7/4/07, effective 6/15/07.

261—53.15(15) Default. Rescinded IAB 7/4/07, effective 6/15/07.

261—53.16(15) Standards for negotiated settlements or discontinuance of collection efforts. Rescinded IAB 7/4/07, effective 6/15/07.

261—53.17(15) Miscellaneous. Rescinded IAB 7/4/07, effective 6/15/07.

261—53.18(15,83GA,SF344) Applicability of CEBA program after July 1, 2009.

53.18(1) Effective July 1, 2009, the CEBA program is rescinded by 2009 Iowa Acts, Senate File 344, and replaced with the grow Iowa values financial assistance program. Rules for the grow Iowa values financial assistance program may be found in 261—Chapter 74.

53.18(2) For awards made prior to July 1, 2009, the rules of 261—Chapter 53 shall govern for purposes of contract administration and closeout of projects. A contract amendment is not allowable if the result of the amendment is to increase the benefits available.

This rule is intended to implement 2009 Iowa Acts, Senate File 344.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code sections 15.315 to 15.320.

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◊ Two or more ARCs

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

[Prior to 7/19/95, see 261—Ch 29]

261—57.1(15E) Purpose and administrative procedures.

57.1(1) *Purpose.* The purpose of this program is to encourage the increased utilization of agricultural commodities produced in this state. The program shall assist in efforts to revitalize rural regions of this state by committing resources to provide financial assistance to new or existing value-added production facilities.

57.1(2) *Administrative procedures.* The VAAPFAP program is subject to the requirements of the department's rules located in 261—Part VII, additional application requirements and procedures, and 261—Part VIII, legal and compliance.

261—57.2(15E) Definitions. In addition to the standard definitions located in 261—Chapter 173, the following definitions apply to the VAAPFAP program:

"Agricultural biomass industry" means businesses that utilize agricultural commodity crops, agricultural by-products, or animal feedstock in the production of chemicals, protein products, or other high-value products.

"Agricultural biotechnology industry" means businesses that utilize scientifically enhanced plants or animals that can be raised by producers and used in the production of high-value products.

"Agriculture" means the science, art, and business of cultivating the soil, producing crops and raising livestock.

"Alternative energy industry" includes businesses involved in the production of ethanol, including gasoline with a mixture of 70 percent or more ethanol, biodiesel, biomass, hydrogen, or in the production of wind energy.

"Committee" means the renewable fuels and coproducts advisory committee established pursuant to Iowa Code section 159A.4.

"Coordinator" means the administrative head of the office of renewable fuels and coproducts appointed by the department of agriculture and land stewardship as provided in Iowa Code section 159A.3.

"Coproduct" means a product other than a renewable fuel which at least in part is derived from the processing of agricultural commodities and which may include corn gluten feed, distillers grain, solubles, a feed supplement, or can be used as livestock feed.

"Farming" means the cultivation of land for the production of agricultural crops, the raising of poultry, the production of eggs, the production of milk, the production of fruit or other horticultural crops, grazing or the production of livestock. Farming shall not include the production of timber, forest products, nursery products, or sod; and farming shall not include a contract where a processor or distributor of farm products or supplies provides spraying, harvesting or other farm services.

"Fund" means the renewable fuels and coproducts fund established pursuant to Iowa Code section 159A.7.

"Innovative" means a new or different agricultural product or a method of processing agricultural products which is an improvement over traditional methods in a new, different, or unusual way.

"Livestock production operations" means the production, feeding and marketing of livestock, poultry and aquaculture. This includes, but is not limited to, beef and dairy cattle, swine, sheep, goat, poultry, turkey and equine operations. It also includes nontraditional agricultural operations such as ostrich, fallow deer, rabbit, fish and other aquaculture.

"Office" means the office of renewable fuels and coproducts created pursuant to Iowa Code section 159A.3.

"Organic products" means Iowa-grown or Iowa-raised agricultural products as defined by 21—Chapter 47, Iowa Organic Program.

"Person" means individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

"Producer-owned, value-added business" means a person who holds an equity interest in the agricultural business and is personally involved in the production of crops or livestock on a regular, continuous, and substantial basis.

"Renewable fuel" means an energy source at least in part derived from an organic compound, capable of powering machinery, including an engine or power plant. A renewable fuel includes but is not limited to ethanol-blended or soydiesel fuel.

"Renewable fuels and coproducts activities" means either of the following:

1. The research, development, production, promotion, marketing, or consumption of renewable fuels and coproducts.
2. The research, development, transfer, or use of technologies which directly or indirectly increases the supply or demand of renewable fuels and coproducts.

"Rural region" means any geographic area which is predominantly rural in nature, that is, having a relatively low population density and where agriculture is the predominant economic activity.

"Soydiesel fuel" means a fuel made of processed soybean oil which is mixed with diesel fuel, the mixture being a minimum of 20 percent processed soybean oil.

"VAAPFAP" means the value-added agricultural products and processes financial assistance program.

"Value-added product" means a product, which through a series of activities or processes, can be sold at a higher price than its original purchase price.

261—57.3(15E) General eligibility. A person is eligible to apply for assistance under this program if the following requirements are met:

1. The existing or proposed facility is located in this state.
2. The person applies to the department of economic development in a manner and according to procedures required by the department.
3. The person submits a business plan which demonstrates managerial and technical expertise.

261—57.4(15E) Program components and eligibility requirements. There will be six components to the VAAPFAP program. For program components described in subrules 57.4(1) through 57.4(4), the department shall prefer producer-owned, value-added businesses, education of producers and management boards in value-added businesses, and other activities that would support the infrastructure in the development of value-added agriculture, and public and private joint ventures involving an institution of higher learning under the control of the state board of regents or a private college or university to acquire assets, research facilities, and leverage moneys in a manner that meets the goals of the grow Iowa values fund. The component(s) include the following:

57.4(1) *Innovative agricultural products and processes component.* An application based on this component shall be considered if either of the following applies:

a. The business will produce a product derived from an agricultural commodity, if the product is not commonly produced in Iowa from an agricultural commodity; or

b. The business will utilize a process to produce a product derived from an agricultural commodity, if the process is not commonly used in Iowa to produce the product.

For purposes of this subrule, a product is "not commonly produced" and a process is "not commonly used" if the product or process is not usually, generally, or ordinarily produced or processed in Iowa.

57.4(2) *Renewable fuel component.* Applications for renewable fuel and ethanol production shall be considered by the department for funding. Applications based on ethanol fuel production must meet the following criteria to be considered for funding:

a. All fermentation, distillation, and dehydration of the ethanol occurs at the proposed facility.

b. The ethanol produced at the proposed facility is at least 190 proof and is denatured. However, if the facility markets the ethanol for further refining, the facility must demonstrate that the refiner produces at least 190 proof ethanol from the ethanol purchased from the facility.

57.4(3) *Agricultural biotechnology, biomass and alternative energy component.* Agricultural business facilities in the agricultural biotechnology industry, agricultural biomass industry, and alternative energy industry are eligible to submit applications.

57.4(4) *Organic and emerging markets component.* Facilities that add value to Iowa agricultural commodities through further processing and development of organic products and emerging markets are eligible for program assistance.

57.4(5) *Project development assistance.* The department, at its discretion, may also provide funding for project development related to proposed projects under this program. Project development assistance could be for the purpose of assisting in departmental evaluation of proposals, or could be one of the proposed activities in a funding request whose further project development could reasonably be expected to lead to a VAAPFAP-eligible commercial enterprise. Feasibility studies and basic research are not eligible for assistance under this program.

57.4(6) *Project creation assistance.* This component is for projects that eventually could be eligible for funding within the other VAAPFAP components. Periodically, a request for proposal (RFP) will be issued based on strategic initiatives developed by the department in consultation with relevant agricultural groups and advisors. The RFP will describe the desired outcome of the proposed effort. The desired outcome could be a new and innovative product, new processing or marketing techniques, or new forms of business operation or collaboration. These efforts could include:

a. Projects that can show need for special financial assistance to engage participation of expertise needed from sources external to the business sponsor of the project.

b. Endeavors where there is a need for financial assistance to plan and organize business consortia or joint ventures among firms or to support costs of special services to be acquired from university or other sources.

c. Situations where there is a need to provide matching funds to businesses to enter competition for federal research and development grants.

261—57.5(15E) Ineligible projects.

57.5(1) The department shall not provide financial assistance to support a value-added production facility if the facility or a person owning a controlling interest in the facility has demonstrated a continuous and flagrant disregard for the health and safety of its employees or the quality of the environment as more fully described in 261—Chapter 172.

57.5(2) The department shall not approve an application for assistance under this program to refinance an existing loan.

57.5(3) The department shall not directly award financial assistance to support an activity directly related to farming as defined in Iowa Code section 9H.1, including the establishment or operation of a livestock production operation, regardless of whether the activity is related to a renewable fuel production facility.

57.5(4) An applicant may not receive more than one award under this program for a single project. However, previously funded projects may receive an additional award(s) if the applicant demonstrates that the funding is to be used for a significant expansion of the project, a new project, or a project which results from previous project development assistance.

57.5(5) The department shall not approve an application for assistance in which VAAPFAP funding would constitute more than 50 percent of the total project costs.

261—57.6(15E) Awards.

57.6(1) *Form.* Financial assistance awarded under this program may be in the form of a loan, forgivable loan, deferred loan, grant, or a combination thereof. The department shall not award more than 25 percent of the amount allocated to the value-added agricultural products and processes financial assistance fund during any state fiscal year to support a single person. The department may finance any size of facility. However, the department may reserve up to 50 percent of the total amount allocated to the fund for purposes of assisting persons requiring $500,000 or less in financial assistance. The

amount shall be reserved until the end of the third quarter of the state fiscal year and may then become available for other projects.

57.6(2) *Amount.*

a. Grants, forgivable loans, and loans shall be awarded on the basis of the impact of the project and the degree to which the project meets the goals of the program.

b. The department reserves the right to negotiate the amount, term payback amount, and other conditions of an award.

261—57.7(15E) Application procedure. Application materials are available on line at www.iowalifechanging.com or from IDED, Business Finance, 200 East Grand Avenue, Des Moines, Iowa 50309, telephone (515)242-4819. A comprehensive business plan must accompany the application and shall include at least the following:

1. Marketing plan for the project;
2. Project budget and status of alternative financing (if applicable);
3. Production operations;
4. Management structure;
5. Personnel needs;
6. Description of product, process or practice;
7. Status of product/service development; and
8. Patent status (if applicable).

261—57.8(15E) Review process. Subject to availability of funds, applications are reviewed and rated by IDED staff on an ongoing basis. Applications will be reviewed by staff for completeness and eligibility. If additional information is required, the applicant shall be provided with notice, in writing, to submit additional information. If the applicant had previously consulted with the coordinator in completion of the application, the department may refer the application to the coordinator for further feasibility studies if deemed necessary. Applications will be reviewed as described in 261—Chapter 175.

The department may consult with other state agencies regarding any possible future environmental, health, or safety issues linked to technology related to the biotechnology industry.

The department reserves the right to informally consult with external resources to assist in the evaluation of projects or to contract with outside consultants, in an amount not to exceed $20,000 per project, for the same purpose.

261—57.9(15E) Deferral process. Rescinded IAB 7/4/07, effective 6/15/07.

261—57.10(15E) Evaluation and rating criteria. The IDED staff shall evaluate and rank applications based on the following criteria:

57.10(1) For the innovative products and processes component:

a. Feasibility (0-25 points). The feasibility of the existing or proposed facility, process, or operation to remain a viable enterprise. Rating factors for this criterion include, but are not limited to, the following: initial capitalization, project budget, financial projections, marketing analysis, marketing plan, management team, and production plan. In order to be eligible for funding, proposals must score at least 15 points on this rating factor.

b. Priority components (0-25 points). The degree to which the proposed project meets one of the four primary program components which include:

1. Innovative agricultural products and processes.
2. Renewable fuels.
3. Agricultural biotechnology, agricultural biomass, and alternative energy.
4. Organic products and emerging markets.

In order to be eligible for funding, proposals must score at least 15 points in the program component under which the applicant is eligible.

c. Utilization (0-25 points). The degree to which the facility will add value to and increase the utilization of agricultural commodities produced in this state. In order to be eligible for funding, proposals must score at least 15 points on this rating factor.

d. Producer ownership (0-15 points). The level of producer ownership will be given additional consideration.

e. The extent to which the existing or proposed facility is located in a rural region of the state (0-10 points).

f. The proportion of local match to be contributed to the project (0-5 points).

g. The level of need of the region where the existing facility is or the proposed facility is to be located (0-5 points). More points are awarded to those projects which exhibit greater need as measured by factors including, but not limited to, the following: regional unemployment rate, poverty level, or other measures of regional fiscal distress.

h. The degree to which the facility produces a coproduct which is marketed in the same locality as the facility (0-5 points).

A minimum score of 65 points is needed for a project to be recommended for funding.

57.10(2) For the project creation assistance component:

a. Any person is eligible to apply except educational or research institutions. However, an educational or research institution may be a partner to an eligible applicant.

b. The evaluation process will focus on the application of new technology and knowledge to agricultural processing and will be based upon the degree to which:

(1) The resulting business has potential to increase the utilization of agricultural commodities in Iowa; and

(2) The resulting business increases value-added economic activities (for example, facilities or employment) within the state of Iowa.

261—57.11(15E) Negotiation and award. Rescinded IAB 7/4/07, effective 6/15/07.

261—57.12(15E) Award process. Rescinded IAB 7/4/07, effective 6/15/07.

261—57.13(15E) Contract. Rescinded IAB 7/4/07, effective 6/15/07.

261—57.14(15E) Administration. Rescinded IAB 7/4/07, effective 6/15/07.

261—57.15(15E) Default. Rescinded IAB 7/4/07, effective 6/15/07.

261—57.16(15E,83GA,SF344) Applicability of VAAPFAP program after July 1, 2009.

57.16(1) Effective July 1, 2009, the VAAPFAP program is rescinded by 2009 Iowa Acts, Senate File 344, section 9, and replaced with the grow Iowa values financial assistance program. Rules for the grow Iowa values financial assistance program may be found in 261—Chapter 74.

57.16(2) For awards made prior to July 1, 2009, the rules of 261—Chapter 57 shall govern for purposes of contract administration and closeout of projects. A contract amendment is not allowable if the result of the amendment is to increase the benefits available.

This rule is intended to implement 2009 Iowa Acts, Senate File 344.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code sections 15E.111 and 15E.112.

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CHAPTER 59
ENTERPRISE ZONE (EZ) PROGRAM

261—59.1(15E) Purpose and administrative procedures.

59.1(1) *Purpose.* The purpose of the establishment of an enterprise zone in a county or city is to promote new economic development in economically distressed areas. Businesses that are eligible and locating or located in an enterprise zone and approved by the department are authorized under this program to receive certain tax incentives and assistance. The intent of the program is to encourage communities to target resources in ways that attract productive private investment in economically distressed areas within a county or city. Projects that have already been initiated before receiving formal application approval by the department shall not be eligible for tax incentives and assistance under this program.

59.1(2) *Administrative procedures.* The EZ program is subject to the requirements of the department's rules located in 261—Part VII, additional application requirements and procedures, and 261—Part VIII, legal and compliance. Part VII and Part VIII include standard definitions; standard program requirements; wage, benefit and investment requirements; application review and approval procedures; contracting; contract compliance and job counting; and annual reporting requirements.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—59.2(15E) Definitions. In addition to the standard definitions located in 261—Chapter 173, the following definitions apply to the EZ program:

"Act" means Iowa Code sections 15E.191 to 15E.197 as amended by 2009 Iowa Acts, Senate File 344.

"Agricultural land" as defined in Iowa Code section 403.17 means real property owned by a person in tracts of ten acres or more and not laid off into lots of less than ten acres or divided by streets and alleys into parcels of less than ten acres, and that has been used for the production of agricultural commodities during three out of the past five years. Such use of property includes, but is not limited to, the raising, harvesting, handling, drying, or storage of crops used for feed, food, seed, or fiber; the care or feeding of livestock; the handling or transportation of crops or livestock; the storage, treatment, or disposal of livestock manure; and the application of fertilizers, soil conditioners, pesticides, and herbicides on crops. "Agricultural land" includes land on which is located farm residences or outbuildings used for agricultural purposes and land on which is located facilities, structures, or equipment for agricultural purposes. "Agricultural land" includes land taken out of agricultural production for purposes of environmental protection or preservation.

"Annual base rent" means the business's annual lease payment minus taxes, insurance and operating or maintenance expenses.

"Biotechnology-related processes" means the use of cellular and biomolecular processes to solve problems or make products. Farming activities shall not be included for purposes of this definition.

"Blighted area" as defined in Iowa Code section 403.17 means an area of a municipality within which the local governing body of the municipality determines that the presence of a substantial number of slum, deteriorated, or deteriorating structures; defective or inadequate street layout; faulty lot layout in relation to size, adequacy, accessibility, or usefulness; insanitary or unsafe conditions; deterioration of site or other improvements; diversity of ownership, tax or special assessment delinquency exceeding the fair value of the land; defective or unusual conditions of title; or the existence of conditions which endanger life or property by fire and other causes; or any combination of these factors; substantially impairs or arrests the sound growth of a municipality, retards the provision of housing accommodations, or constitutes an economic or social liability and is a menace to the public health, safety, or welfare in its present condition and use. A disaster area referred to in Iowa Code section 403.5, subsection 7, constitutes a "blighted area." "Blighted area" does not include real property assessed as agricultural land or property for purposes of property taxation.

"Business closure" means a business that has completed the formal legal process of dissolution, withdrawal or cancellation with the secretary of state.

"Commission" or *"enterprise zone commission"* means the enterprise zone commission established by a city or county to review applications for incentives and assistance for businesses located within or requesting to locate within certified enterprise zones over which the enterprise zone commission has jurisdiction under the Act.

"Contractor" or *"subcontractor"* means a person who contracts with an eligible business or subcontracts with a contractor for the provision of property, materials, or services for the construction or equipping of a facility, located within the economic development zone, of the eligible business.

"Eligible business" means a business which meets the requirements of rule 261—59.5(15E).

"Enterprise zone" means a site or sites certified by the department of economic development board for the purpose of attracting private investment within economically distressed counties or areas of cities within the state.

"Permanent layoff" means the loss of jobs to an out-of-state location, the cessation of one or more production lines, the removal of manufacturing machinery and equipment, or similar actions determined to be equivalent in nature by the department. A permanent layoff does not include a layoff of seasonal employees or a layoff that is seasonal in nature. For purposes of these rules, a permanent layoff must occur on or after February 1, 2007.

"Project" means the activity, or set of activities, proposed in the application by the business, which will result in accomplishing the goals of the enterprise zone program, and for which the business requests the benefits of the enterprise zone program.

"Project jobs" means all of the new jobs to be created by the location or expansion of the business in the enterprise zone that meet the qualifying wage threshold requirements described in 261—Chapter 174.

"Tax credit certificate" means a document issued by the department to an eligible business which indicates the amount of unused investment tax credit that the business is requesting to receive in the form of a refund. A tax credit certificate shall contain the taxpayer's name, address, and tax identification number, the date of project completion, the amount of the tax credit certificate, the tax year for which the credit will be claimed, and any other information required by the department of revenue or the department.

"Transportation enterprise zone" means a site or sites certified by the Iowa department of economic development board for the purpose of attracting private investment within economically distressed areas of cities within the state which are in close proximity to transportation facilities.

"Value-added agricultural products" means agricultural products which, through a series of activities or processes, can be sold at a higher price than the original purchase price.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—59.3(15E) Enterprise zone certification. An eligible county or an eligible city may request the board to certify an area meeting the requirements of the Act and these rules as an enterprise zone. Certified enterprise zones will remain in effect for a period of ten years from the date of certification by the board. A county may request zone certification under subrule 59.3(1) at any time prior to December 1, 2003. A county or city may request zone certification under subrules 59.3(2), 59.3(3), 59.3(4) and 59.3(6) at any time prior to July 1, 2010.

59.3(1) *County—eligibility based on distress criteria in section 15E.194, Iowa Code (2001).*

a. Requirements. To be eligible for enterprise zone certification, a county must meet at least two of the following criteria:

(1) The county has an average weekly wage that ranks among the bottom 25 counties in the state based on the 1995 annual average weekly wage for employees in private business.

(2) The county has a family poverty rate that ranks among the top 25 counties in the state based on the 1990 census.

(3) The county has experienced a percentage population loss that ranks among the top 25 counties in the state between 1990 and 1995.

(4) The county has a percentage of persons 65 years of age or older that ranks among the top 25 counties in the state based on the 1990 census.

b. Zone parameters. Up to 1 percent of a county area may be certified as an enterprise zone. A county may establish more than one enterprise zone. The total amount of land certified as enterprise zones, other than those zones certified pursuant to subrules 59.3(3), 59.3(4) and 59.3(6), shall not exceed in the aggregate 1 percent of the total county area. An eligible county containing a city whose boundaries extend into an adjacent county may establish an enterprise zone in an area of the city located in the adjacent county if the adjacent county's board of supervisors adopts a resolution approving the establishment of the enterprise zone in the city and the two counties enter into an agreement pursuant to Iowa Code chapter 28E regarding the establishment of the enterprise zone.

59.3(2) *County—eligibility based on distress criteria in section 15E.194, Iowa Code (2003).*

a. Requirements. To be eligible for enterprise zone certification, a county must meet at least two of the following criteria:

(1) The county has an average weekly wage that ranks among the bottom 25 counties in the state based on the 2000 annual average weekly wage for employees in private business.

(2) The county has a family poverty rate that ranks among the top 25 counties in the state based on the 2000 census.

(3) The county has experienced a percentage population loss that ranks among the top 25 counties in the state between 1995 and 2000.

(4) The county has a percentage of persons 65 years of age or older that ranks among the top 25 counties in the state based on the 2000 census.

b. Zone parameters. Up to 1 percent of a county area may be certified as an enterprise zone. A county may establish more than one enterprise zone. The total amount of land certified as enterprise zones, other than those zones certified pursuant to subrules 59.3(3), 59.3(4) and 59.3(6), shall not exceed in the aggregate 1 percent of the total county area. An eligible county containing a city whose boundaries extend into an adjacent county may establish an enterprise zone in an area of the city located in the adjacent county if the adjacent county's board of supervisors adopts a resolution approving the establishment of the enterprise zone in the city and the two counties enter into an agreement pursuant to Iowa Code chapter 28E regarding the establishment of the enterprise zone.

59.3(3) *City—eligibility.*

a. Requirements. To be eligible for enterprise zone certification, a designated area within a city which includes at least three census tracts with at least 50 percent of the population in each tract located in the city, as shown by the 2000 certified federal census, must meet at least two of the following criteria:

(1) The area has a per capita income of $12,648 or less based on the 2000 census.

(2) The area has a family poverty rate of 12 percent or higher based on the 2000 census.

(3) Ten percent or more of the housing units are vacant in the area.

(4) The valuations of each class of property in the designated area is 75 percent or less of the citywide average for that classification based upon the most recent valuations for property tax purposes.

(5) The area is a blighted area, as defined in Iowa Code section 403.17.

b. Population limits. A city which includes at least three census tracts with at least 50 percent of the population in each tract located in the city, as shown by the 2000 certified federal census, may request enterprise zone certification by the board. The zone shall consist of one or more contiguous census tracts, as determined in the most recent federal census, or alternative geographic units approved by the department, for that purpose. In creating an enterprise zone, an eligible city may designate as part of the area tracts or approved geographic units located in a contiguous city if such tracts or approved geographic units otherwise meet the criteria on their own and the contiguous city agrees to be included in the enterprise zone.

c. Zone parameters. A city may establish more than one enterprise zone. The area meeting the requirements for eligibility for an enterprise zone shall not be included for the purpose of determining the 1 percent aggregate area limitation for enterprise zones. If there is an area in the city which meets the requirements for eligibility for an urban or rural enterprise community under Title XIII of the federal Omnibus Budget Reconciliation Act of 1993, such area shall be certified by the state as an enterprise zone.

59.3(4) *Transportation enterprise zone—eligibility.*

a. Transportation enterprise zone requirements. To be eligible for transportation enterprise zone certification, a designated area within a city which includes at least three census tracts with at least 50 percent of the population in each tract located in the city, as shown by the 2000 certified federal census, must be a blighted area as defined in Iowa Code section 403.17, but must not be agricultural land or property, and must include or be within four miles of at least three of the following:

(1) A commercial service airport, as defined by the Iowa department of transportation.

(2) A barge terminal or a navigable waterway, as defined by the Iowa department of transportation.

(3) Entry to a rail line.

(4) Entry to an interstate highway.

(5) Entry to a commercial and industrial highway network as identified pursuant to Iowa Code section 313.2A.

b. Transportation enterprise zone population limits. A city which includes at least three census tracts with at least 50 percent of the population in each tract located in the city, as shown by the 2000 certified federal census, may request transportation enterprise zone certification by the board.

c. Transportation enterprise zone parameters. A city may establish more than one transportation enterprise zone. The area being designated as a transportation enterprise zone shall not exceed four square miles. The area meeting the requirements for eligibility for a transportation enterprise zone shall not be included for the purpose of determining the 1 percent aggregate area limitation for enterprise zones.

d. Transportation enterprise zone award restrictions. In the period from July 1, 2007, through June 30, 2010, the cumulative total of benefits awarded to eligible businesses shall not exceed $25 million per fiscal year. Value-added property tax exemption benefits provided by the city shall not count against the $25 million. Transportation enterprise zones established pursuant to this subrule shall not be used to provide incentives for eligible housing businesses to construct new housing units or rehabilitate existing housing units.

59.3(5) *Certification procedures.*

a. Request with supporting documentation. All requests for certification shall be made using the application provided by the department and shall include the following attachments:

(1) A legal description of the proposed enterprise zone area and a detailed map showing the boundaries of the proposed enterprise zone.

(2) If the proposed county enterprise zone contains a city whose boundaries extend into an adjacent county, the resolution of the board of supervisors of the adjacent county approving the establishment of the zone and a copy of an executed 28E agreement.

(3) Resolution of the city council or board of supervisors, as appropriate, requesting certification of the enterprise zone(s). Included within this resolution may be a statement of the schedule of value-added property tax exemptions that will be offered to all eligible businesses that are approved for incentives and assistance. If a property tax exemption is made applicable only to a portion of the property within the enterprise zone, a description of the uniform criteria which further some planning objective that has been established by the city or county enterprise zone commission and approved by the eligible city or county must be submitted to the department. Examples of acceptable "uniform criteria" that may be adopted include, but are not limited to, wage rates, capital investment levels, types and levels of employee benefits offered, job creation requirements, and specific targeted industries. "Planning objectives" may include, but are not limited to, land use, rehabilitation of distressed property, or brownfields remediation.

The city or county shall forward a copy of the official resolution listing the property tax exemption schedule(s) to the department and to the local assessor.

b. Board review. The board will review requests for enterprise zone certification. The board may approve, deny, or defer a request for zone certification.

c. Notice of board action. The department will provide notice to a city or county of the board's certification, denial, or deferral of the city's or county's request for certification of an area as an enterprise zone. If an area is certified by the board as an enterprise zone, the notice will include the date of the zone certification and the date this certification expires.

d. Amendments. A certified enterprise zone may be amended at the request of the city or county that originally applied for the zone certification. Requests must be in writing and be received by the department prior to December 1, 2003, if the county is eligible pursuant to subrule 59.3(1) or prior to July 1, 2010, if the county or city is eligible pursuant to subrule 59.3(2), 59.3(3), or 59.3(4). Requests must include the enterprise zone name and number, as established by the department when the zone was certified, the date the zone was originally certified, the reason an amendment is being requested, the number of acres the zone will contain if the amendment is approved, and a resolution of the city council or board of supervisors, as appropriate, requesting the amendment. A legal description of the amended enterprise zone and a map which shows both the original enterprise zone boundaries and the proposed changes to those boundaries shall accompany the written request.

A city requesting an amendment that consists of an area being added to the enterprise zone must include documentation that demonstrates that the area being added meets the eligibility requirements of subrule 59.3(3) or 59.3(4). A city requesting an amendment that consists of an area being removed from the enterprise zone must include documentation that demonstrates that the remaining area still meets the eligibility requirements of subrule 59.3(3) or 59.3(4).

An amendment shall not extend the zone's ten-year expiration date, as established when the zone was initially certified by the board or when the board approved an extension. The board will review the request and may approve, deny, or defer the proposed amendment. A county or city shall not be allowed to remove a portion of an enterprise zone that contains an eligible business or eligible housing business that has received incentives and assistance under this program and whose agreement, described in rule 59.13(15E), has not yet expired.

e. Decertification. A county or city may request decertification of an enterprise zone. Requests must be in writing and be received by the department prior to December 1, 2003, if the county is eligible pursuant to subrule 59.3(1) or prior to July 1, 2010, if the county or city is eligible pursuant to subrule 59.3(2), 59.3(3), or 59.3(4). Requests must include the enterprise zone name and number, as established by the department when the zone was certified, the date the zone was originally certified, and a resolution of the city council or board of supervisors, as appropriate, requesting the decertification. Requests for enterprise zone decertification will be reviewed by the board and may be approved, denied or deferred. If the county or city requesting decertification designates a subsequent enterprise zone, the expiration date of the subsequent enterprise zone shall be the same as the expiration date of the decertified enterprise zone. A county or city shall not be allowed to decertify an enterprise zone that contains an eligible business or eligible housing business that has received incentives and assistance under this program and whose agreement, described in rule 59.13(15E), has not yet expired.

f. Extensions. Prior to the expiration of an enterprise zone, a city or county may apply for a one-time extension.

(1) Counties eligible under subrule 59.3(1) but not eligible under subrule 59.3(2). A county may request that the board extend the expiration date of a previously certified enterprise zone. The extended expiration date will be one year following the complete publication of the 2010 federal census, as determined by the department.

In applying for this one-time extension, the county may redefine the boundaries of the enterprise zone provided the size of the enterprise zone remains unchanged. A county shall not be allowed to redefine the boundaries of an enterprise zone if the redefinition would result in removing an area that contains an eligible business or eligible housing business that has received incentives and assistance under this program and whose agreement, described in rule 59.13(15E), has not yet expired.

(2) Counties eligible under subrule 59.3(2). A county may request that the board extend the expiration date of a previously certified enterprise zone by ten years. In applying for this one-time, ten-year extension, the county may redefine the boundaries of the enterprise zone provided the redefinition of the enterprise zone does not cause the county to exceed the 1 percent aggregate area limitation for enterprise zones. A county shall not be allowed to redefine the boundaries of an enterprise zone if the redefinition would result in removing an area that contains an eligible business or eligible housing business that has received incentives and assistance under this program and whose agreement, described in rule 59.13(15E), has not yet expired.

(3) Cities eligible under subrule 59.3(3). A city may request that the board extend the expiration date of a previously certified enterprise zone by ten years provided that at the time of the request, the enterprise zone meets the eligibility requirements established by paragraph 59.3(3)*"a."* In applying for this one-time, ten-year extension, the city may redefine the boundaries of the enterprise zone provided that the redefined enterprise zone meets the eligibility requirements established in paragraph 59.3(3)*"a."* A city shall not be allowed to redefine the boundaries of an enterprise zone if the redefinition would result in removing an area that contains an eligible business or eligible housing business that has received incentives and assistance under this program and whose agreement, described in rule 59.13(15E), has not yet expired.

(4) Extension requests. Extension requests shall be made using the form provided by the department and shall be accompanied by a resolution of the city council or board of supervisors, as appropriate, requesting the extension of the enterprise zone. The board will review requests for enterprise zone extensions. The board may approve, deny, or defer an extension request.

59.3(6) *City or county with business closure.*

a. Requirements. A city of any size or any county may designate an enterprise zone at any time prior to July 1, 2010, when a business closure or permanent layoff occurs involving the loss of full-time employees, not including retail employees, at one place of business totaling at least 1,000 employees or 4 percent of the county's resident labor force based upon the most recent annual resident labor force statistics from the department of workforce development, whichever is lower.

b. Zone parameters. The enterprise zone may be established on the property of the place of business that has closed or imposed a permanent layoff, and the enterprise zone may include an area up to an additional three miles adjacent to the property. The closing business or business imposing a permanent layoff shall not be eligible to receive incentives or assistance under this program. The area meeting the requirements for enterprise zone eligibility under this subrule shall not be included for the purpose of determining the area limitation pursuant to Iowa Code section 15E.192, subsection 4.

c. Certification procedures. All requests for certification shall be made using the application provided by the department. The board will review requests for enterprise zone certification. The board may approve, deny, or defer a request for zone certification.

d. Amendments. A city or county which designated an enterprise zone under this subrule on or after June 1, 2000, may request an amendment to include additional area within the enterprise zone. Requests must be in writing and be approved by the department within three years of the date the enterprise zone was originally certified. Requests must include the enterprise zone name and number, as established by the department when the zone was certified, the date the zone was originally certified, and the number of acres the zone will contain if the amendment is approved. A legal description of the amended enterprise zone and a map which shows both the original enterprise zone boundaries and the proposed changes to those boundaries shall accompany the written request.

e. Restrictions. Enterprise zones established pursuant to this subrule shall not be used to provide incentives for eligible housing businesses to construct new housing units or rehabilitate existing housing units.

261—59.4(15E) Enterprise zone commission. Following notice of enterprise zone certification by the board, the applicant city or county shall establish an enterprise zone commission. The commission shall review applications from eligible businesses and eligible housing businesses located in the zone and forward approved applications to the department for final review and approval. A county eligible to designate enterprise zones which contains a city which is eligible to designate enterprise zones, upon mutual agreement between the board of supervisors and the city council and in consultation with the department, may elect to establish one enterprise zone commission to serve both the county and the city.

59.4(1) *Commission composition.*

a. County enterprise zone commission. A county shall have only one enterprise zone commission to review applications for incentives and assistance for businesses (including eligible housing businesses) located or requesting to locate within a certified enterprise zone. The enterprise zone commission shall consist of nine members. Five of these members shall be comprised of:

(1) One representative of the county board of supervisors,

(2) One member with economic development expertise selected by the department,

(3) One representative of the county zoning board,

(4) One member of the local community college board of directors, and

(5) One representative of the local workforce development center selected by the Iowa workforce development department unless otherwise designated by a regional advisory board.

The five members identified above shall select the remaining four members. If the enterprise zone is located in a county that does not have a county zoning board, the representatives identified in 59.4(1)*"a"*(1), (2), (4), and (5) shall select an individual with zoning expertise to serve as a member of the commission.

b. City enterprise zone commission. A city in which an eligible enterprise zone is certified shall have only one enterprise zone commission. A city which includes at least three census tracts with at least 50 percent of the population in each census tract located in the city, as shown by the 2000 federal census, in which an eligible enterprise zone is certified shall establish an enterprise zone commission to review applications from qualified businesses located within or requesting to locate within an enterprise zone to receive incentives or assistance. The commission shall consist of nine members. Six of these members shall consist of:

(1) One representative of an international labor organization,

(2) One member with economic development expertise chosen by the department of economic development,

(3) One representative of the city council,

(4) One member of the local community college board of directors,

(5) One member of the city planning and zoning commission, and

(6) One representative of the local workforce development center selected by the Iowa workforce development department unless otherwise designated by a regional advisory board.

The six members identified above shall select the remaining three members. If the enterprise zone consists of an area meeting the requirements for eligibility for an urban enterprise community under Title XIII of the federal Omnibus Budget Reconciliation Act of 1993, one of the remaining three members shall be a representative of that community. If a city contiguous to the city designating the enterprise zone is included in an enterprise zone, a representative of the contiguous city, chosen by the city council, shall be a member of the commission.

59.4(2) *Department review of composition.*

a. Once a county or city has established an enterprise zone commission, the county or city shall provide the department with the following information to verify that the commission is constituted in accordance with the Act and these rules:

(1) The name and address of each member.

(2) An identification of what group the member is representing on the commission.

(3) Copies of the resolution or other necessary action of a governing body, as appropriate, by which a member was appointed to the commission.

(4) Any other information that the department may reasonably request in order to permit it to determine the validity of the commission's composition.

b. If a city has established an enterprise zone commission prior to July 1, 1998, the city may petition to the department of economic development to change the structure of the existing commission. A petition to amend the structure of an existing city enterprise zone commission shall include the following:

(1) The names and addresses of the members of the existing commission.

(2) The date the commission was approved by the department.

(3) The proposed changes the city is requesting in the composition of the commission.

(4) Copies of the resolution or other necessary action of a governing body, as appropriate, by which a member was appointed to the commission.

59.4(3) *Commission policies and procedures.* Each commission shall develop policies and procedures which shall, at a minimum, include:

a. Processes for receiving and evaluating applications from qualified businesses seeking to participate within the enterprise zone; and

b. Operational policies of the commission such as meetings; and

c. A process for the selection of commission officers and the filling of vacancies on the commission; and

d. The designation of staff to handle the day-to-day administration of commission activities.

e. Additional local eligibility requirements for businesses, if any, as discussed in subrule 59.9(1).

261—59.5(15E) Eligibility and negotiations.

59.5(1) *Program categories.* To participate in the enterprise zone program, a business must qualify under one of two categories: an eligible business or an eligible housing business. Refer to rule 261—59.6(15E) for a description of the eligibility requirements and benefits available to a qualified "eligible business." Refer to rule 261—59.8(15E) for a description of the eligibility requirements and benefits available to a qualified "eligible housing business."

59.5(2) *Negotiations.* The department reserves the right to negotiate the terms and conditions of an award and the amount of all program benefits except the following benefits: the new jobs supplemental credit; the value-added property tax exemption; and the refund of sales, service and use taxes paid to contractors and subcontractors. The criteria, as applicable to the category under which the business is applying, to be used in the negotiations to determine the amount of tax incentives and assistance include but are not limited to:

a. The number and quality of jobs to be created. Factors to be considered include but are not limited to full-time, career path jobs; number of jobs meeting or exceeding the qualifying wage threshold requirements described in 261—Chapter 174; turnover rate; fringe benefits provided; safety; skill level.

b. The wage levels of the jobs to be created.

c. The amount of capital investment to be made.

d. The level of need of the business. Factors to be considered include but are not limited to the degree to which the business needs the tax incentives and assistance in order for the project to proceed. Methods of documenting need may include criteria such as financial concerns; risk of the business's locating in or relocating to another state; or return on investment concerns.

e. The economic impact and cost to the state and local area of providing tax incentives and assistance in relation to the public gains and benefits to be provided by the business. Factors to be considered include but are not limited to the amount of tax credits likely to be used by the business and the impact on the local and state tax base and economic base.

f. Other state or federal financial assistance received or applied for by the business for the project.

59.5(3) *Limitation on negotiations.* Rescinded IAB 11/9/05, effective 12/14/05.

261—59.6(15E) Eligible business.

59.6(1) *Requirements.* A business which is or will be located, in whole or in part, in an enterprise zone is eligible to be considered to receive incentives and assistance under the Act if the business meets all of the following:

a. No closure or reduction. The business has not closed or reduced its operation in one area of the state and relocated substantially the same operation into the enterprise zone. This requirement does not prohibit a business from expanding its operation in an enterprise zone if existing operations of a similar nature in the state are not closed or substantially reduced.

b. No retail. The business is not a retail business or a business whose entrance is limited by a cover charge or membership requirement.

c. Employee benefits. The business offers or will offer a sufficient benefits package to its employees as defined in 261—Chapter 173.

d. Wage levels. The business pays or will pay the qualifying wage threshold for the enterprise zone program as established in 261—Chapter 174 and defined in 261—Chapter 173. However, in any circumstance, the wage paid by the business for the project jobs shall not be less than $7.50 per hour.

The local enterprise zone commission may establish higher company eligibility wage thresholds if it so desires.

e. Job creation or retention. The business expansion or location must result in at least ten full-time project jobs. The time period allowed to create the jobs and the required period to retain the jobs are described in 261—Chapter 187.

f. Capital investment. The business makes a capital investment of at least $500,000.

g. Location within zone. If the business is only partially located in an enterprise zone, the business must be located on contiguous land.

59.6(2) *Additional information.* In addition to meeting the requirements under subrule 59.6(1), an eligible business shall provide the enterprise zone commission with all of the following:

a. The long-term strategic plan for the business, which shall include labor and infrastructure needs.

b. Information dealing with the benefits the business will bring to the area.

c. Examples of why the business should be considered or would be considered a good business enterprise.

d. The impact the business will have on other Iowa businesses in competition with it. The enterprise zone commission shall make a good faith effort to identify existing Iowa businesses within an industry in competition with the business being considered for assistance. The enterprise zone commission shall make a good faith effort to determine the probability that the proposed financial assistance will displace employees of the existing businesses. In determining the impact on businesses in competition with the business being considered for assistance, jobs created or retained as a result of other jobs being displaced elsewhere in the state shall not be considered direct jobs created or retained.

e. A report describing all violations of environmental law or worker safety law within the last five years. If, upon review of the application, the enterprise zone commission finds that a business has a record of violations of the law, statutes, rules, or regulations that tends to show a consistent pattern, the enterprise zone commission shall not make an award of financial assistance to the business unless the commission finds either that the violations did not seriously affect public health, public safety, or the environment, or, if such violations did seriously affect public health, public safety, or the environment, that mitigating circumstances were present.

59.6(3) *Benefits.* The department reserves the right to negotiate the amount of all program benefits except the following benefits: the new jobs supplemental credit; the value-added property tax exemption; and the refund of sales, service and use taxes paid to contractors and subcontractors. The following incentives and assistance may be available to an eligible business within a certified enterprise zone, subject to the amount of incentives and assistance negotiated by the department with the eligible business and agreed upon as described in an executed agreement, only when the average wage of all the new project jobs meets the minimum wage requirements of 59.6(1)*"d"*:

a. New jobs supplemental credit. An approved business shall receive a new jobs supplemental credit from withholding in an amount equal to 1½ percent of the gross wages paid by the business, as provided in Iowa Code section 15E.197. The supplemental new jobs credit available under this program is in addition to and not in lieu of the program and withholding credit of 1½ percent authorized under Iowa Code chapter 260E. Additional new jobs created by the project, beyond those that were agreed to in the original agreement as described in 261—59.12(15E), are eligible for the additional 1½ percent withholding credit as long as those additional jobs meet the local enterprise zone wage eligibility criteria and are an integral part or a continuation of the new location or expansion. Approval and administration of the supplemental new jobs credit shall follow existing procedures established under Iowa Code chapter 260E. Businesses eligible for the new jobs training program are those businesses engaged in interstate commerce or intrastate commerce for the purpose of manufacturing, processing, or assembling products, conducting research and development, or providing services in interstate commerce, but exclude retail, health or professional services.

b. Value-added property tax exemption.

(1) The county or city for which an eligible enterprise zone is certified may exempt from property taxation all or a portion of the value added to the property upon which an eligible business locates or expands in an enterprise zone and which is used in the operation of the eligible business. This exemption

shall be authorized by the city or county that would have been entitled to receive the property taxes, but is electing to forego the tax revenue for an eligible business under this program. The amount of value added for purposes of Iowa Code section 15E.196 shall be the amount of the increase in assessed valuation of the property following the location or expansion of the business in the enterprise zone.

(2) If an exemption is made applicable only to a portion of the property within an enterprise zone, there must be approved uniform criteria which further some planning objective established by the city or county zone commission. These uniform criteria must also be approved by the eligible city or county. Examples of acceptable "uniform criteria" that may be adopted include, but are not limited to, wage rates, capital investment levels, types and levels of employee benefits offered, job creation requirements, and specific targeted industries. "Planning objectives" may include, but are not limited to, land use, rehabilitation of distressed property, or brownfields remediation.

(3) The exemption may be allowed for a period not to exceed ten years beginning the year value added by improvements to real estate is first assessed for taxation in an enterprise zone.

(4) This value-added property tax exemption may be used in conjunction with other property tax exemptions or other property tax-related incentives such as property tax exemptions that may exist in Urban Revitalization Areas or Tax Increment Financing (TIF). Property tax exemptions authorized under Iowa Code chapter 427B may not be used, as stated in Iowa Code section 427B.6, in conjunction with property tax exemptions authorized by city council or county board of supervisors within the local enterprise zone.

c. Investment tax credit and insurance premium tax credit.

(1) Investment tax credit. An eligible business may claim an investment tax credit as provided in Iowa Code section 15.333. A corporate income tax credit may be claimed of up to a maximum of 10 percent of the new investment which is directly related to new jobs created by the location or expansion of the business in the enterprise zone. The credit may be used against a tax liability imposed for individual income tax, corporate income tax, franchise tax, or against the moneys and credits tax imposed in Iowa Code section 533.24.

1. Five-year amortization period. For projects approved on or after July 1, 2005, the tax credit shall be amortized equally over a five-year period which the department, in consultation with the eligible business, will define. The five-year amortization period will be specified in the agreement referenced in rule 261—59.13(15E).

2. Flow-through of tax credits. If the business is a partnership, subchapter S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 or 501A and filing as a partnership for federal tax purposes, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit allowed.

3. Seven-year carryforward. Any credit in excess of tax liability for the tax year may be credited to the tax liability for the following seven years or until depleted, whichever occurs first.

4. Refund of unused tax credit. Subject to prior approval by the department in consultation with the department of revenue, an eligible business whose project primarily involves the production of value-added agricultural products or biotechnology-related processes may elect to apply for a refund for all or a portion of an unused tax credit.

5. IRS Section 521. For purposes of this paragraph, an eligible business includes a cooperative as described in Section 521 of the United States Internal Revenue Code which is not required to file an Iowa corporate income tax return.

6. Maximum capital expenditures stated in agreement. The business participating in the enterprise zone may not claim an investment tax credit for capital expenditures above the amount stated in the agreement described in 261—59.12(15E). An eligible business may instead, prior to project completion, seek to amend the contract, allowing the business to receive an investment tax credit for additional capital expenditures.

(2) Insurance premium tax credit. The insurance premium tax credit benefit is available for a business that submits an application for enterprise zone participation on or after July 1, 1999. If the business is an insurance company, the business may claim an insurance premium tax credit as provided in Iowa Code section 15E.196.

1. Five-year amortization period. For projects approved on or after July 1, 2005, the tax credit shall be amortized equally over a five-year period which the department, in consultation with the eligible business, will define. The five-year amortization period will be specified in the agreement referenced in rule 261—59.13(15E).

2. Credit of up to 10 percent of new investment. An Iowa insurance premium tax credit may be claimed of up to a maximum of 10 percent of the new investment which is directly related to new jobs created by the location or expansion of the business in the enterprise zone.

3. Seven-year carryforward. Any credit in excess of tax liability for the tax year may be credited to the tax liability for the following seven years or until depleted, whichever occurs first.

4. Maximum capital expenditures as stated in agreement. The business participating in the enterprise zone may not claim an investment tax credit for capital expenditures above the amount stated in the agreement described in 261—59.12(15E). An eligible business may instead seek to amend the contract, allowing the business to receive an investment tax credit for additional capital expenditures, or may elect to submit a new application within the enterprise zone.

(3) Eligible capital expenditures. For purposes of this rule, the capital expenditures eligible for the investment tax credit or the insurance premium tax credit under the enterprise zone program are:

1. The costs of machinery and equipment as defined in Iowa Code section 427A.1(1)*"e"* and *"j"* purchased for use in the operation of the eligible business, the purchase prices of which have been depreciated in accordance with generally accepted accounting principles;

2. The cost of improvements made to real property which is used in the operation of the eligible business; and

3. The annual base rent paid to a third-party developer for a period equal to the term of lease agreement but not to exceed ten years, provided that the cumulative costs of the base rent payments for that period do not exceed the cost of the land and the third-party developer's costs to build or renovate the building. Annual base rent shall be considered only when the project includes the construction of a new building or the major renovation of an existing building. The eligible business shall enter into a lease agreement with the third-party developer for a minimum of five years.

(4) Real property. For business applications received on or after July 1, 1999, for purposes of the investment tax credit claimed under Iowa Code section 15.333 and for business applications received on or after May 26, 2000, for purposes of the insurance premium tax credit claimed under Iowa Code section 15.333A, subsection 1, the purchase price of real property and any existing buildings and structures located on the real property will also be considered a new investment in the location or expansion of an eligible business. However, if within five years of purchase, the eligible business sells or disposes of, razes or otherwise renders unusable the land, buildings, or other existing structures for which tax credit was claimed under Iowa Code section 15.333 or under Iowa Code section 15.333A, subsection 1, the income tax liability, or where applicable the insurance premium tax liability, of the eligible business for the year in which the property is sold, disposed of, razed, or otherwise rendered unusable shall be increased by one of the following amounts:

1. One hundred percent of the tax credit claimed under this section if the property ceases to be eligible for the tax credit within one year after being placed in service.

2. Eighty percent of the tax credit claimed under this section if the property ceases to be eligible for the tax credit within two years after being placed in service.

3. Sixty percent of the tax credit claimed under this section if the property ceases to be eligible for the tax credit within three years after being placed in service.

4. Forty percent of the tax credit claimed under this section if the property ceases to be eligible for the tax credit within four years after being placed in service.

5. Twenty percent of the tax credit claimed under this section if the property ceases to be eligible for the tax credit within five years after being placed in service.

(5) Refunds. An eligible business whose project primarily involves the production of value-added agricultural products and whose application was approved by the department on or after May 26, 2000, or whose project primarily involves biotechnology-related processes and whose application was approved

by the department on or after July 1, 2005, may elect to receive as a refund all or a portion of an unused investment tax credit.

1. The department will determine whether a business's project primarily involves the production of value-added agricultural products or biotechnology-related processes. Effective July 1, 2001, an eligible business that elects to receive a refund shall apply to the department for a tax credit certificate.

2. The business shall apply for a tax credit certificate using the form provided by the department. Requests for tax credit certificates will be accepted between May 1 and May 15 of each fiscal year. Only those eligible businesses that have completed projects before the May 1 filing date may apply for a tax credit certificate. For a cooperative described in Section 521 of the United States Internal Revenue Code, the department shall require the cooperative to submit a list of members whom the cooperative wishes to receive a tax credit certificate for their prorated share of ownership. The cooperative shall submit its list in a computerized electronic format that is compatible with the system used or designated by the department. The computerized list shall, at a minimum, include the name, address, social security number or taxpayer identification number, business telephone number and ownership percentage, carried out to six decimal places, of each cooperative member eligible for a tax credit certificate. The cooperative shall also submit a total dollar amount of the unused investment tax credits for which the cooperative's members are requesting a tax credit certificate.

3. The department will make public by June 1 of each year the total number of requests for tax credit certificates and the total amount of requested tax credit certificates that have been submitted. The department will issue tax credit certificates within a reasonable period of time.

4. The department shall not issue tax credit certificates which total more than $4 million during a fiscal year. If the department receives applications for tax credit certificates in excess of $4 million, the applicants shall receive certificates for a prorated amount. In such a case, the tax credit requested by an eligible business will be prorated based upon the total amount of requested tax credit certificates received during the fiscal year. This proportion will be applied to the amount requested by each eligible business to determine the amount of the tax credit certificate that will be distributed to each business for the fiscal year. For example, if an eligible business submits a request in the amount of $1 million and the total amount of requested tax credit certificates equals $8 million, the business will be issued a tax credit certificate in the amount of $500,000:

$$\frac{\$4 \text{ million}}{\$8 \text{ million}} = 50\% \times \$1 \text{ million} = \$500{,}000.$$

5. Tax credit certificates shall not be valid until the tax year following project completion. The tax credit certificates shall not be transferred except in the case of a cooperative as described in Section 521 of the United States Internal Revenue Code. For such a cooperative, the individual members of the cooperative are eligible to receive the tax credit certificates. Tax credit certificates shall be used in tax years beginning on or after July 1, 2001. A business shall not claim a refund of unused investment tax credit unless a tax credit certificate issued by the department is attached to the taxpayer's tax return for the tax year during which the tax credit is claimed. Any unused investment tax credit in excess of the amount of the tax credit certificate issued by the department may be carried forward for up to seven years after the qualifying asset is placed in service or until the eligible business's unused investment tax credit is depleted, whichever occurs first. An eligible business may apply for tax credit certificates once each year for up to seven years after the qualifying asset is placed in service or until the eligible business's unused investment tax credit is depleted, whichever occurs first. For example, an eligible business which completes a project in October 2001 and has an investment tax credit of $1 million may apply for a tax credit certificate in May 2002. If, because of the proration of the $4 million of available refundable credits for the fiscal year, the business is awarded a tax credit certificate in the amount of $300,000, the business may claim the $300,000 refund and carry forward the unused investment tax credit of $700,000 for up to seven years or until the credit is depleted, whichever occurs first.

d. Research activities credit. A business is eligible to claim a research activities credit as provided in Iowa Code section 15.335. This benefit is a corporate tax credit for increasing research activities in

this state during the period the business is participating in the program. For purposes of claiming this credit, a business is considered to be "participating in the program" for a period of ten years from the date the business's application was approved by the department. This credit equals 6½ percent of the state's apportioned share of the qualifying expenditures for increasing research activities. The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in this state to total qualified research expenditures. This credit is in addition to the credit authorized in Iowa Code section 422.33. If the business is a partnership, subchapter S corporation, limited liability company, or an estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit allowed. Any tax credit in excess of the tax liability shall be refunded to the eligible business with interest computed under Iowa Code section 422.25. In lieu of claiming a refund, the eligible business may elect to have the overpayment credited to its tax liability for the following year.

For projects approved on or after July 1, 2005, "research activities" includes the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa. A renewable energy generation component will no longer be considered innovative when more than 200 megawatts of installed effective name plate capacity has been achieved. Research activities credits awarded under this program and the high quality job creation program for innovative renewable energy generation components shall not exceed a total of $1 million.

e. Refund of sales, service and use taxes paid to contractors or subcontractors.

(1) A business is eligible for a refund of sales, service and use taxes paid to contractors and subcontractors as authorized in Iowa Code section 15.331A.

1. An eligible business may apply for a refund of the sales, service and use taxes paid under Iowa Code chapters 422 and 423 for gas, electricity, water or sewer utility services, goods, wares, or merchandise, or on services rendered, furnished, or performed to or for a contractor or subcontractor and used in the fulfillment of a written contract relating to the construction or equipping of a facility within the enterprise zone.

2. Taxes attributable to intangible property and furniture and furnishings shall not be refunded. To receive a refund of the sales, service and use taxes paid to contractors or subcontractors, the eligible business must, within one year after project completion, make an application to the department of revenue. For new manufacturing facilities, "project completion" means the first date upon which the average annualized production of finished product for the preceding 90-day period at the manufacturing facility operated by the eligible business within the enterprise zone is at least 50 percent of the initial design capacity of the facility. For existing facilities, "project completion" means the date of completion of all improvements included in the enterprise zone project.

(2) If the project is the location or expansion of a warehouse or distribution center in the enterprise zone, the approved business may be entitled to a refund of sales and use taxes attributable to racks, shelving, and conveyor equipment. The approved business shall, within one year of project completion, make written application to the department for a refund. The application must include the refund amount being requested and documentation such as invoices, contracts or other documents which substantiate the requested amount. The department, in consultation with the department of revenue, will validate the refund amount and instruct the department of revenue to issue the refund.

The aggregate combined total amount of refunds and tax credits attributable to sales and use taxes on racks, shelving, and conveyor equipment issued by the department to businesses approved for high quality job creation program, new capital investment program, new jobs and income program, and enterprise zone program benefits shall not exceed $500,000 during a fiscal year. Tax refunds and tax credits will be issued on a first-come, first-served basis. If an approved business's application does not receive a refund or tax credits due to the limitation of $500,000 per fiscal year, the approved business's application shall be considered in the succeeding fiscal year.

f. New jobs insurance premium tax credit. Rescinded IAB 11/9/05, effective 12/14/05.

g. Limitation on receiving incentives. Rescinded IAB 11/9/05, effective 12/14/05.

59.6(4) *Duration of benefits.* An enterprise zone designation shall remain in effect for ten years following the date of certification. Any state or local incentives or assistance that may be conferred must

be conferred before the designation expires. However, the benefits of the incentive or assistance may continue beyond the expiration of the zone designation.

59.6(5) *Application review and submittal.* Eligible businesses shall first submit applications for enterprise zone program benefits to the local enterprise zone commission. Commission-approved applications shall be forwarded to the department for final review and approval.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—59.7(15E) Alternative eligible business. Rescinded IAB 9/17/03, effective 10/22/03.

261—59.8(15E) Eligible housing business. An eligible housing business includes a housing developer, housing contractor, or nonprofit organization.

59.8(1) *Requirements.* A housing business shall satisfy all of the following as conditions to receiving the benefits described in this rule.

a. The housing business must build or rehabilitate either:

(1) A minimum of four single-family homes located in that part of a city or county in which there is a designated enterprise zone, or

(2) One multiple dwelling unit building containing three or more individual dwelling units located in that part of a city or county in which there is a designated enterprise zone.

For purposes of this subrule, rehabilitation means any project in which the costs of improvements to the property are equal to or greater than 25 percent of the acquisition cost of the property.

b. The single-family homes or dwelling units which are rehabilitated or constructed by the housing business shall include the necessary amenities. When completed and made available for occupancy, the single-family homes or dwelling units shall meet the United States Department of Housing and Urban Development's housing quality standards and local safety standards.

c. The eligible housing business shall complete its building or rehabilitation within two years from the time the business begins construction on the single-family homes and dwelling units. The failure to complete construction or rehabilitation within two years shall result in the eligible housing business's becoming ineligible and subject to the repayment requirements and penalties in the agreement described in rule 261—59.13(15E).

d. An eligible housing business shall provide the enterprise zone commission with all of the following information:

(1) The long-term plan for the proposed housing development project, including labor and infrastructure needs.

(2) Information dealing with the benefits the proposed housing development project will bring to the area.

(3) Examples of why the proposed development project should be considered a good housing development project.

(4) An affidavit that it has not, within the last five years, violated state or federal environmental and worker safety statutes, rules, and regulations or if such violations have occurred that there were mitigating circumstances or such violations did not seriously affect public health or safety or the environment.

(5) Information showing the total costs and sources of project financing that will be utilized for the new investment directly related to housing for which the business is seeking approval for a tax credit provided in subrule 59.8(2), paragraph *"a."*

(6) The names of the partners if the business is a partnership, the names of the shareholders if the business is an S corporation, or the names of the members if the business is a limited liability company. The amount of each partner's, shareholder's or member's expected share of the percentage of benefits should be included.

59.8(2) *Benefits.* A business that qualifies under the "eligible housing business" category may be eligible to receive the following benefits:

a. Investment tax credit. An eligible housing business may claim a tax credit up to a maximum of 10 percent of the new investment which is directly related to the building or rehabilitating of a minimum of four single-family homes located in that part of a city or county in which there is a designated enterprise

zone or one multiple dwelling unit building containing three or more individual dwelling units located in that part of a city or county in which there is a designated enterprise zone.

(1) New investment which is directly related to the building or rehabilitating of homes includes, but is not limited to, the following costs: land, surveying, architectural services, building permits, inspections, interest on a construction loan, building materials, roofing, plumbing materials, electrical materials, amounts paid to subcontractors for labor and material provided, concrete, labor, landscaping, appliances normally provided with a new home, heating and cooling equipment, millwork, drywall and drywall materials, nails, bolts, screws, and floor coverings.

(2) New investment does not include the machinery, equipment, or hand or power tools necessary to build or rehabilitate homes.

(3) In determining the amount of tax credits to be awarded to a project, the department shall not include the portion of the project cost financed through federal, state, and local government tax credits, grants, and forgivable loans.

(4) The tax credit shall not exceed 10 percent of $140,000 for each home or individual unit in a multiple dwelling unit building.

(5) This tax credit may be used to reduce the tax liability imposed under Iowa Code chapter 422, division II, III, or V, or chapter 432. The tax credit may be taken on the tax return for the tax year in which the project is certified for occupancy. Any credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until depleted, whichever occurs earlier. If the business is a partnership, S corporation, limited liability company, or estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit allowed. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, or estate or trust, except in projects using low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the housing development. The approved housing business using federal Section 42 tax credits may designate each owner's or participant's share or percentage of the benefits.

(6) The department shall issue tax credit certificates once per year or when the department determines it to be necessary and appropriate to approve housing businesses eligible to receive the housing enterprise zone tax credit. The eligible housing business may claim the tax credit by attaching the certificate to the business's tax return for the year in which the housing units are completed.

(7) If the approved housing business is using federal low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the project, the department shall issue a transferable tax credit certificate to the eligible housing business. The amount of any replacement tax credit certificates requested by the housing business will be based on documentation provided to the department by the applicant or by the Iowa finance authority and should be consistent with the amount contained in the project's 8609 CPA Certification on file with the Iowa finance authority.

(8) Housing enterprise zone tax credit certificates issued to eligible housing businesses also using low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the project may be transferred to any person. Within 90 days of the sale of the housing enterprise zone tax credit, the eligible housing business must return the tax credit certificate issued by the department so that replacement tax credit certificate(s) can be issued. The original tax credit certificate shall be accompanied by a written statement from the eligible housing business which contains the names, tax identification numbers, and addresses of the taxpayers to which the tax credits are being transferred, along with the denomination that each replacement tax credit certificate is to carry and any other information required by the department of revenue. Within 30 days of receiving the eligible housing business's tax credit certificate and written statement, the department shall issue replacement tax credit certificate(s).

(9) The tax credit certificate shall also be transferable if the housing development is located in a brownfield site as defined in Iowa Code section 15.291 or if the housing development is located in a blighted area as defined in Iowa Code section 403.17. Not more than $3 million worth of tax credits for housing developments that are located in a brownfield site as defined in Iowa Code section 15.291 or housing developments located in a blighted area as defined in Iowa Code section 403.17 shall be

transferred in a calendar year. The $3 million annual limit does not apply to tax credits awarded to an eligible business having low-income housing tax credits authorized under Section 42 of the Internal Revenue Code to assist in the financing of the housing development. The department may approve an application for tax credit certificates for transfer from an eligible housing business located in a brownfield site as defined in Iowa Code section 15.291 or in a blighted area as defined in Iowa Code section 403.17 that would result in the issuance of more than $3 million of tax credit certificates for transfer, provided that the department, through negotiation with the eligible housing business, allocates those tax credit certificates for transfer over more than one calendar year. The department shall not issue more than $1,500,000 in tax credit certificates for transfer to any one eligible housing business located in a brownfield site as defined in Iowa Code section 15.291 or in a blighted area as defined in Iowa Code section 403.17. If $3 million in tax credit certificates for transfer have not been issued at the end of a calendar year, the remaining tax credit certificates for transfer may be issued at the end of a calendar year, the remaining tax credit certificates for transfer may be issued in advance to an eligible housing business scheduled to receive a tax credit certificate for transfer in a later calendar year. Anytime the department issues a tax credit certificate for transfer which has not been allocated at the end of a calendar year, the department may prorate the remaining certificates to more than one eligible applicant. If the entire $3 million of tax credit certificates for transfer is not issued in a given calendar year, the remaining amount may be carried over to a succeeding calendar year.

(10) The department will process requests for transfer of the tax credit and issuance of the replacement tax credit certificates for housing developments that are located in brownfield sites as defined in Iowa Code section 15.291 or blighted areas as defined in Iowa Code section 403.17 at the time of application or in writing each calendar year. Eligible requests for transfer of these credits will be considered in the order they are received. The transfer of the credit by replacement tax credit certificate will be limited to $3 million per calendar year and $1,500,000 per development per calendar year. Requests received after the $3 million limit is reached will be considered for the following year's allocation after any previously approved requests or negotiated allocations of the credit remaining from the current or previous years have been processed. When housing enterprise zone benefits are awarded to one housing business in an amount exceeding the annual transferable limit of $1,500,000 per year, the housing business may negotiate with the department to receive the tax credit benefits from future years' limits when possible. These limits do not apply to housing tax credits authorized by Section 42 of the Internal Revenue Code or to other housing enterprise zone developments not located in brownfield sites as defined in Iowa Code section 15.291 or blighted areas as defined in Iowa Code section 403.17.

b. Sales, service, and use tax refund. An approved housing business shall receive a sales, service, and use tax refund for taxes paid by an eligible housing business including an eligible housing business acting as a contractor or subcontractor, as provided in Iowa Code section 15.331A.

59.8(3) *Application submittal and review.* An eligible housing business shall first submit an application to the commission for approval. The commission shall forward applications that it has approved to receive benefits and assistance to the department for final review and approval.

261—59.9(79GA,ch141) Eligible development business. Rescinded IAB 11/9/05, effective 12/14/05.

261—59.10(15E) Commission review of businesses' applications.

59.10(1) *Additional commission eligibility requirements.* Under the Act, a commission is authorized to adopt additional eligibility requirements related to compensation and benefits that businesses within a zone must meet in order to qualify for benefits. Additional local requirements that may be considered could include, but are not limited to, the types of industries or businesses the commission wishes to receive enterprise zone benefits; requirements that preference in hiring be given to individuals who live within the enterprise zone; higher wage eligibility threshold requirements than would otherwise be required; higher job creation eligibility threshold requirements than would otherwise be required; the level of benefits required; local competition issues; or any other criteria the commission deems appropriate. If a commission elects to adopt more stringent requirements than those contained in the

Act and these rules for a business to be eligible for incentives and assistance, these requirements shall be submitted to the department.

59.10(2) *Application.* The department will develop a standardized application that it will make available for use by a business applying for benefits and assistance as an eligible business, an eligible housing business or an eligible development business. The commission may add any additional information to the application that it deems appropriate for a business to qualify as an eligible business, an eligible housing business or an eligible development business. If the commission determines that a business qualifies for inclusion in an enterprise zone and that it is eligible for benefits under the Act, the commission shall submit an application for incentives or assistance to the department.

261—59.11(15E) Other commission responsibilities.

59.11(1) Commissions have the authority to adopt a requirement that preference in hiring be given to individuals who live within the enterprise zone. If it does so, the commission shall work with the local workforce development center to determine the labor availability in the area.

59.11(2) Commissions shall examine and evaluate building codes and zoning in enterprise zones and make recommendations to the appropriate governing body in an effort to promote more affordable housing development.

261—59.12(15E) Department action on eligible applications. The department may approve, deny, or defer applications from qualified businesses. In reviewing applications for incentives and assistance under the Act, the department will consider the following:

59.12(1) *Compliance with the requirements of the Act and administrative rules.* Each application will be reviewed to determine if it meets the requirements of the Act and these rules. Specific criteria to be reviewed include, but are not limited to: medical and dental insurance coverage; wage levels; number of jobs to be created; and capital investment level.

59.12(2) *Competition.* The department shall consider the impact of the eligible business on other businesses in competition with it and compare the compensation package of businesses in competition with the business being considered for incentives and assistance under this program, to ensure an overall economic gain to the state.

59.12(3) *Displacement of workers.* The department will make a good-faith effort to determine the probability that the proposed incentives will displace employees of existing businesses. In determining the impact on businesses in competition with the business seeking incentives or assistance, jobs created as a result of other jobs being displaced elsewhere in the state shall not be considered direct jobs created.

59.12(4) *Violations of law.* The department will review each application to determine if the business has a record of violations of law as described in 261—Chapter 172.

59.12(5) *Commission's recommendations and additional criteria.* For each application from a business, the department will review the local analysis (including any additional local criteria) and recommendation of the enterprise zone commission in the zone where the business is located, or plans to locate.

59.12(6) *Other relevant information.* The department may also review an application using factors it reviews in other department-administered financial assistance programs which are intended to assess the quality of the jobs pledged.

59.12(7) *Negotiations.* The department may enter into negotiations regarding the amount of tax incentives and assistance the business may be eligible to receive. The department reserves the right to negotiate the amount of all program benefits except the following benefits: the new jobs supplemental credit; the value-added property tax exemption; and the refund of sales, service and use taxes paid to contractors and subcontractors. The criteria to be used in the negotiations to determine the amount of tax incentives and assistance are as described in subrule 59.5(2) and are subject to the limitations stated in subrule 59.5(3).

261—59.13(15E) Agreement. Rescinded IAB 7/4/07, effective 6/15/07.

261—59.14(15E) Compliance; repayment requirements; recovery of value of incentives. Rescinded IAB 7/4/07, effective 6/15/07.

These rules are intended to implement Iowa Code sections 15.333, 15.333A, and 15E.191 to 15E.196 and 2009 Iowa Acts, Senate File 344.

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CHAPTER 60
ENTREPRENEURIAL VENTURES ASSISTANCE (EVA) PROGRAM

261—60.1(15) Purpose and administrative procedures.

60.1(1) *Purpose.* The department of economic development administers the entrepreneurial ventures assistance (EVA) program. The purpose of the entrepreneurial ventures assistance program is to encourage the development of entrepreneurial venture planning and managerial skills in conjunction with the delivery of a financial assistance program for business start-ups and expansions.

60.1(2) *Administrative procedures.* The EVA program is subject to the requirements of the department's rules located in 261—Part VII, additional application requirements and procedures, and 261—Part VIII, legal and compliance.

261—60.2(15) Definitions. In addition to the standard definitions located in 261—Chapter 173, the following definitions apply to the EVA program:

"Early-stage industry company" or *"early-stage company"* means a company with three years or less of experience in a particular industry.

"Eligible applicant" means an individual or business that has consulted with and obtained a letter of endorsement from an IDED-approved business accelerator or from another IDED-recognized entrepreneurial development organization.

"Eligible business" means a start-up company, an early-stage company, or an existing company that is developing a new product or technology.

"EVA" means the entrepreneurial ventures assistance program, authorized by Iowa Code sections 15.338 and 15.339.

261—60.3(15) Eligibility requirements.

60.3(1) In order to be eligible for assistance, the business, or proposed business, must be located in the state of Iowa.

60.3(2) If the business is a sole proprietorship or a partnership, all applicable business owners must apply. If the business is a limited liability company, a limited liability partnership, or a corporation, the application must be submitted and signed by an individual who has been authorized by the business to do so.

60.3(3) In order to be eligible for assistance, the business owner or owners (or appropriate individual(s) in a limited liability company, limited liability partnership or corporation) must consult with and obtain a letter of endorsement from an IDED-approved business accelerator or from another recognized entrepreneurial development organization such as a John Pappajohn Entrepreneurial Center (JPEC), a Small Business Development Center (SBDC), or an equivalent organization recognized by IDED.

60.3(4) In order to be eligible for assistance, the individual or business must have a business plan which details the business's growth strategy, management team (if applicable), production/management plan, marketing plan, financial plan, and other standard elements of a business plan.

261—60.4(15) Financial assistance. Applicants may apply to IDED for financial assistance to assist with their business start-up or early-stage growth. The applicant may request up to $250,000 for start-up or early-stage growth activities to be used for business expenses and to leverage conventional financing from commercial lenders or private investors. Assistance will generally be made in staged investments with amounts to be determined by company development, growth, and defined milestones. The assistance under this program is limited to 50 percent or less of the total original capitalization, if a new business, or total project costs, if an existing business. Funds may be used to purchase machinery, equipment, or software, or for working capital needs, or other business expenses deemed reasonable and appropriate by IDED. Awards will be in the form of an equitylike investment (e.g., royalty agreement, deferred loan). A single recipient is limited to $250,000 in total financial assistance.

261—60.5(15) Technical assistance. Applicants may also apply for assistance in paying for consulting, or technical assistance, either in conjunction with the request for financial assistance, or after a period of time that the business has been in operation. Technical assistance of this nature is limited to no more than $25,000 per applicant.

261—60.6(15) Application process. Applications must be submitted in the format required by the department. Applications, the business plan, and related material shall be submitted on line or by mail to Entrepreneurial Ventures Assistance Program, Division of Business Development, Business Finance, Iowa Department of Economic Development, 200 East Grand Avenue, Des Moines, Iowa 50309.

261—60.7(15) Review criteria.

60.7(1) Applications will first be reviewed for completeness. If additional information is required, the program staff shall send the applicant notice to submit the additional needed information. The applicant shall submit the requested information within a reasonable time period in order to ensure further action on the request.

60.7(2) The applications will then be reviewed for content of the business plan, and an evaluation of the business's potential viability and potential for growth. The department may consult with the JPEC centers, or other knowledgeable agencies or individuals, as a part of the review process.

60.7(3) The following items will be reviewed and evaluated:

a. Type of business.

(1) Highest priority will be given to businesses in sectors of the Iowa economy with the greatest start-up and growth potential for Iowa, including but not limited to:

1. Biotechnology (including drugs and pharmaceuticals and value-added agricultural products);
2. Recyclable materials;
3. Software development and computer-related products;
4. Advanced materials;
5. Advanced manufacturing; and
6. Medical and surgical instruments.

(2) Assistance may be provided to industries other than those listed in "1" through "6" above; however, the applicant will have to provide a strong rationale regarding how that industry diversifies, strengthens or otherwise enhances Iowa's economy. Eligibility may be established by an industry other than those listed if that industry can provide rationale regarding the industry's benefit to Iowa's economic base. Rationale that is provided will be reviewed by department staff to determine eligibility as a targeted industry. Items that will be considered in determining an industry's benefit to Iowa's economic base will include:

1. The majority of the products or services produced by the industry are exported out of Iowa;
2. The inputs for the products produced in the industry are raw materials available in Iowa or are provided by Iowa suppliers;
3. The goods or services produced by this industry diversify Iowa's economy;
4. The goods or services provided by the industry resulted in, or will result in, a decrease in the importation of foreign-made goods into the United States;
5. The industry shows potential for future growth;
6. The functions of the industry do not produce harmful effects for Iowa's natural environment; and
7. Whether the average wages of the majority of the occupations in the industry are above the statewide average wage.

Businesses engaged in retail sales, personal services, consulting, franchises, the provision of health care or other professional services, and distributors of products or services will not be considered targeted industries and are not eligible for this program.

b. Management team and management expertise. Factors considered here would be whether the applicant(s) has a background (including education, training, work experience, and other factors) which

will be helpful and useful in the business in question. Also considered would be the degree to which the applicant's background is fully documented.

c. Business capitalization. Factors considered here would be the original sources of financing for the business. Although all projects must have at least 50 percent of their financing from sources other than the EVA program, preference would be given to those applications where the other sources of financing were even higher than 50 percent.

d. Strength of business plan. Factors considered here would be the quality of the business plan and how well it addresses all elements of the business, such as:

1. A description of the company and the overall industry;
2. The product and production plan;
3. The market, competition, and the marketing strategy;
4. The management team and business operations;
5. Patent issues (if applicable), critical risks and problems; and
6. Financial information and plan.

The strength of the business plan will be the most important factor in the evaluation and rating of applications. Rating factors in paragraphs *"a," "b,"* and *"c"* above will be evaluated as either satisfactory or not satisfactory. However, the business plan will be rated on an actual numerical or comparative scale. Those applications which are satisfactory on factors in paragraphs *"a," "b,"* and *"c"* above and which rate highest on strength of business plan will be funded first.

261—60.8(15) Negotiation, decision, and award process. Rescinded IAB 7/4/07, effective 6/15/07.

261—60.9(15) Monitoring, reporting, and follow-up. Rescinded IAB 7/4/07, effective 6/15/07.

261—60.10(15,83GA,SF344) Applicability of EVA program after July 1, 2009.

60.10(1) Effective July 1, 2009, the EVA program is rescinded by 2009 Iowa Acts, Senate File 344, section 9, and replaced with the grow Iowa values financial assistance program. Rules for the grow Iowa values financial assistance program may be found in 261—Chapter 74.

60.10(2) For awards made prior to July 1, 2009, the rules of 261—Chapter 60 shall govern for purposes of contract administration and closeout of projects. A contract amendment is not allowable if the result of the amendment is to increase the benefits available.

This rule is intended to implement 2009 Iowa Acts, Senate File 344.

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These rules are intended to implement Iowa Code sections 15.338 and 15.339.

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CHAPTER 61
PHYSICAL INFRASTRUCTURE ASSISTANCE PROGRAM (PIAP)

261—61.1(15E) Purpose and administrative procedures.

61.1(1) *Purpose.* The purpose of the physical infrastructure assistance program (PIAP) is to provide financial assistance for the physical infrastructure necessary to aid in community or business development or redevelopment projects which involve substantial investment; provide for the opportunity for creating quality, high-wage jobs; and have statewide impact.

61.1(2) *Administrative procedures.* The PIAP program is subject to the requirements of the department's rules located in 261—Chapters 171 through 175 and 261—Chapters 187 through 189.

261—61.2(15E) Eligible activities.

61.2(1) Eligible activities for assistance include, but are not limited to, physical infrastructure improvements of:

a. Any mode of transportation infrastructure; or

b. Public works and utilities such as water, sewer, power, or telecommunications; or

c. Physical improvements which mitigate, prevent, or eliminate environmental contaminants.

61.2(2) The department may also fund other activities deemed appropriate and consistent with program purposes.

261—61.3(15E) Eligibility requirements. To be eligible for program funds a business shall, as a result of the proposed project, demonstrate that it meets each of the following requirements:

61.3(1) *Quality, high-wage jobs.* A business shall create or retain quality, high-wage, full-time jobs or provide the foundation for creation of such jobs. The quality of the jobs will be measured by factors such as the wage level and benefits provided.

61.3(2) *Substantial capital investment.* A business shall make a substantial private capital investment in the project. Capital investment is defined as the costs associated with land acquisition, site development, building construction or improvements, fixtures, machinery and equipment.

61.3(3) *Statewide impacts.* An applicant shall show, as a result of the proposed project, significant beneficial impacts to the state.

61.3(4) *No closure or reduction in operations.* A business shall not close or substantially reduce operations at one location in Iowa and relocate substantially the same operation elsewhere in the state if the closure or reduction results in loss of employment.

61.3(5) *Other funding sources unable to assist.* The business's project must be of a size, nature or scope that the project could not be assisted through, or eligible for, financial assistance for the entirety of the project from other existing private, local, or state funds or programs.

261—61.4(15E) Application procedures.

61.4(1) *Application required.* To access program funds, an application must be submitted in the format specified by the department. Applications will be accepted from a city or county on behalf of the city or county, a nonprofit local development corporation, publicly owned utility, private utility, private developer or redeveloper. A business may also submit an application on its own behalf. Applicants other than a city or county shall obtain formal support from the city or county where the project is to be located.

61.4(2) *Application contents.* Applications shall include the following:

a. A project description including the private activity involved and the physical infrastructure affected.

b. A description of the consistency of the proposed project with state and local policies and plans for development. Project coordination with other physical infrastructure projects in the area shall also be included in this project description.

c. An identification of the number of jobs to be created or retained as a result of the project and an explanation of why they are considered quality, high-wage jobs. The explanation shall include the job classifications, the number of jobs that meet or exceed the qualifying wage threshold described in

261—Chapter 174, and benefits to be provided to the employees. If no jobs are to be created or retained as a direct result of the project, the applicant shall provide a description of how the project creates the foundation for the creation of high-quality jobs in the future.

d. An identification of the amount, terms, and sources of all proposed public and private investments that the project will leverage and a statement concerning whether the other financing has been secured or is still to be arranged.

e. Cost estimates for all project activities.

f. A time frame within which the project will be completed.

g. A description of the immediate (within 24 months) impacts as a result of the project.

h. A description of the long-term (beyond 24 months), speculative impacts as a result of the project.

i. A description of statewide impacts as a result of the project.

j. An explanation as to why the project could not be entirely assisted through, or is not eligible for, financial assistance from other existing private, local, or state funds or programs.

k. The type of financing (e.g., loan, forgivable loan) sought and the amount of assistance requested.

l. Signed acknowledgements from the city or county, or both, and the business stating that the project is supported and will occur if PIAP funding is provided.

m. Current company financials.

261—61.5(15E) Application review criteria, performance measures.

61.5(1) Quality of the jobs. In determining the quality of the jobs, the department will consider the wage levels, benefit package, turnover rate, full-time and career positions, and other relevant factors.

61.5(2) Substantiality of the capital investment pledged by the business.

61.5(3) Closure or relocation of the business's operations and any resulting loss of employment.

61.5(4) Access to other funding. The department will review the application to assess whether the project could reasonably be funded under other existing private, local, or state funds or programs.

61.5(5) The number of jobs to be created or retained or how the project contributes to the future creation of high-quality jobs.

61.5(6) The amount, terms, and sources of all proposed public and private investments that the project will leverage.

61.5(7) The immediate and long-term impacts the proposed project will have on the economy of the community and the state.

61.5(8) The financial need of the business.

61.5(9) The degree of coordination the project has with state and local development plans.

61.5(10) The feasibility of the project.

61.5(11) Any other information about the business that has a bearing on the likely success of the project.

61.5(12) Each fiscal year the department may allocate up to $5 million from the Iowa values fund to the PIAP program for eligible projects that shall not be subject to job and wage requirements established in Iowa Code section 15G.112. The department will establish performance measures for projects funded through this allocation. Performance measures may include but are not limited to the requirement of tenant businesses involved in business infrastructure projects to meet minimum job and wage requirements pursuant to Iowa Code section 15G.112, the requirement that a certain percentage of building space resulting from the project be leased to business tenants, documentation that the project is part of a larger redevelopment effort, or other measures deemed appropriate by the department. Performance measures for such projects will be determined at the time of award and incorporated into any contract between the department and the applicant. Performance measures shall be met within three years of the completion of the project.

261—61.6(15E) Award process. Rescinded IAB 7/4/07, effective 6/15/07.

261—61.7(15E) Forms of assistance available; award amount.

61.7(1) *Forms of assistance.* Funding is available for providing assistance in the form of a loan, forgivable loan, loan guarantee, cost-share, or any combination deemed to be the most efficient in facilitating the infrastructure project.

61.7(2) *Amount of award.* The maximum award per project shall not exceed $1 million. The director may waive this award limit upon a showing that the business exceeds the eligibility requirements for the program; or the wages to be paid are in excess of those paid in the community or the industry; or the project will bring a substantial economic benefit to the community or the state. If an award would exceed the $1 million level, the director shall advise and consult with the IDED board prior to approving a waiver of the award limit. Any award in excess of $1 million shall be secured by an irrevocable letter of credit, unless funded through special allocation of PIAP funds, up to $5 million, established in subrule 61.5(12).

261—61.8(15E) Program administration. Rescinded IAB 7/4/07, effective 6/15/07.

261—61.9(15E) Applicability of PIAP program after July 1, 2009.

61.9(1) Effective July 1, 2009, the PIAP program is rescinded by 2009 Iowa Acts, Senate File 344, section 9, and replaced with the grow Iowa values financial assistance program. Rules for the grow Iowa values financial assistance program may be found in 261—Chapter 74.

61.9(2) For awards made or contracts entered into prior to July 1, 2009, the rules of 261—Chapter 61 shall govern for purposes of contract administration and closeout of projects. A contract amendment is not allowable if the result of the amendment is to increase the benefits available.

This rule is intended to implement 2009 Iowa Acts, Senate File 344.

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These rules are intended to implement Iowa Code section 15E.175.

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CHAPTER 68
HIGH QUALITY JOBS PROGRAM (HQJP)

261—68.1(15) Administrative procedures and definitions.

68.1(1) *Administrative procedures.* The HQJP is subject to the requirements of the department's rules located in 261—Part VII, additional application requirements and procedures, and 261—Part VIII, legal and compliance. Part VII and Part VIII include standard definitions; standard program requirements; wage, benefit and investment requirements; application review and approval procedures; contracting; contract compliance and job counting; and annual reporting requirements.

68.1(2) *Definitions.* In addition to the standard definitions located in 261—Chapter 173, the following definitions apply to the HQJP:

"Act" means Iowa Code sections 15.326 to 15.337 as amended by 2009 Iowa Acts, Senate File 344.

"Annual base rent" means the business's annual lease payment minus taxes, insurance and operating or maintenance expenses.

"Biotechnology-related processes" means the use of cellular and biomolecular processes to solve problems or make products. For purposes of this definition, farming activities shall not be included.

"Community" means a city, county, or other entity established pursuant to Iowa Code chapter 28E.

"Contractor or subcontractor" means a person who contracts with the eligible business or subcontracts with a contractor for the provision of property, materials, or services for the construction or equipping of a facility of the eligible business.

"Eligible business" means a business meeting the conditions of Iowa Code section 15.329 as amended by 2009 Iowa Acts, Senate File 344, section 12.

"High quality jobs" means created or retained jobs that meet the wage requirements established in subrule 68.2(4) and subrules 68.2(7) and 68.2(8) when applicable.

"Program" means the high quality jobs program.

"Project" means the activity, or set of activities, proposed in the application by the business which will result in accomplishing the goals of the program and for which the business is requesting tax incentives and assistance. A project shall include the start-up, location, expansion, or modernization of a business.

"Value-added agricultural products" means agricultural products which, through a series of activities or processes, can be sold at a higher price than the original purchase price.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—68.2(15) Eligibility requirements.

68.2(1) *Community approval.* If the qualifying investment is $10 million or more, the community in which the business's project is or will be located shall approve by ordinance or resolution the start-up, location, expansion, or modernization of the business for purposes of receiving tax incentives and assistance under this program.

68.2(2) *Closures or relocations.* The business shall not close or substantially reduce operations in one area of this state and relocate substantially the same operations in a community in another area of this state. This subrule shall not be construed to prohibit the business from expanding its operations in a community if existing operations of a similar nature in this state are not closed or substantially reduced.

68.2(3) *No retail or service businesses.* The business shall not be a retail or service business. For purposes of this subrule, a service business is a business providing services to a local consumer market which does not have a significant proportion of its sales coming from outside the state.

68.2(4) *Created and retained jobs.* The business shall create or retain jobs as part of a project.

a. The business shall pay the qualifying wage threshold for HQJP as established in 261—Chapter 174.

b. If the business is creating jobs, the business shall demonstrate that the jobs will pay at least 100 percent of the qualifying wage threshold at the start of the project completion period, at least 130 percent of the qualifying wage threshold by the project completion date, and at least 130 percent of the qualifying wage threshold until the maintenance period completion date.

c. If the business is retaining jobs, the business shall demonstrate that the jobs retained will pay at least 130 percent of the qualifying wage threshold throughout both the project completion period and the maintenance period.

68.2(5) *Determination of sufficient benefits.* The business shall provide a sufficient package of benefits to each employee holding a created or retained job. The business shall offer a sufficient benefits package to its employees as defined in 261—Chapter 173.

68.2(6) *Sufficient fiscal impact.* The business shall demonstrate that the jobs created or retained will have a sufficient impact on state and local government revenues as determined by the department after calculating the fiscal impact ratio of the project.

68.2(7) *Violations of law.* If the department finds that a business has a record of violations of law over a period of time that tends to show a consistent pattern as described in 261—Chapter 172, the business shall not qualify for tax incentives and assistance under this program.

68.2(8) *Competition.* The department shall consider the impact of the proposed project on other Iowa businesses in competition with the business that is seeking tax incentives and assistance. The department shall make a good faith effort to identify existing Iowa businesses within an industry in competition with the business that is seeking tax incentives and assistance. The department shall make a good faith effort to determine the probability that the proposed financial assistance will negatively impact other existing Iowa businesses including but not limited to displacing employees of the existing business.

68.2(9) *Other benefits.* A business may seek benefits and assistance for its project from other applicable federal, state, and local programs in addition to those provided in this program. However, a business which has received assistance for its project from the wage-benefit tax credit program or the enterprise zone program shall not be eligible for tax incentives and assistance under this program. A business which has received assistance for its project from the new jobs and income program or the new capital investment program shall not be eligible for tax incentives and assistance under this program for the same project. However, the business may receive tax incentives and assistance under this program for subsequent projects.

68.2(10) *Ineligibility—no high quality jobs created or retained.* If a project is creating or retaining jobs, but none are high quality jobs, then the project is not eligible to receive benefits and assistance under this program.

[**ARC 7557B**, IAB 2/11/09, effective 3/18/09; **ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—68.3(15) Application process and review.

68.3(1) *Application.* The department shall develop a standardized application and make it available to a business applying for tax incentives and assistance. The application procedures are as follows:

a. An application will not be accepted after project initiation.

b. A signature from the appropriate community official shall be required on the application as indication that the community is aware of and supports the project. For a project with a qualifying investment of $10 million or more, the community ordinance or resolution approving the project shall accompany the application.

c. Each application will be reviewed by the department. The department may request additional information from the business that is applying for tax incentives and assistance or may use other resources to obtain the needed information.

d. If the business meets the eligibility requirements, the department staff will prepare a report which includes a summary of the project and a recommendation on the amount of tax incentives and assistance to be offered to the business.

68.3(2) *Wage waiver.* Rescinded IAB 7/4/07, effective 6/15/07.

68.3(3) *Benefit values.* Rescinded IAB 7/4/07, effective 6/15/07.

68.3(4) *Negotiations.* The department reserves the right to enter into negotiations with the business regarding the amount of tax incentives and assistance the business shall receive. All forms of tax incentives and assistance available under the program may be subject to negotiations. The department shall consider all of the following factors with respect to entering into negotiations with the business:

a. Level of need. The three general justifiable reasons for assistance are as follows:

(1) The business can raise only a portion of the debt and equity necessary to complete the project. A gap between sources and uses exists and state or federal funds or both are needed to fill the gap.

(2) The business can raise sufficient debt and equity to complete the project, but the returns are inadequate to motivate a company decision maker to proceed with the project. Project risks outweigh the rewards.

(3) The business is deciding between a site in Iowa (site A) and a site in another state (site B) for its project. The business argues that the project will cost less at site B and will require a subsidy to equalize costs in order to locate at site A. The objective is to quantify the cost differential between site A and site B.

Projects that have already been initiated will not be considered for funding.

b. Quality of the jobs. The department shall place greater emphasis on projects involving created or retained jobs that:

(1) Have a higher wage scale. Businesses that have wage scales substantially higher than those of existing Iowa businesses in that industry shall be considered as providing the highest quality of jobs.

(2) Have a lower turnover rate.

(3) Are full-time or career-type positions.

c. Percentage of created jobs defined as high quality jobs. The department will consider the number of high quality jobs to be created versus the total number of created jobs in determining what amount of tax incentives and assistance to offer the business.

d. Economic impact. In measuring the economic impact to this state, the department shall place greater emphasis on projects which demonstrate the following:

(1) A business with a greater percentage of sales out-of-state or of import substitution.

(2) A business with a higher proportion of in-state suppliers.

(3) A project which would provide greater diversification of the state economy.

(4) A business with fewer in-state competitors.

(5) A potential for future job growth.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—68.4(15) Tax incentives and assistance.

68.4(1) *Sales and use tax refund.* Pursuant to Iowa Code section 15.331A, the approved business may be entitled to a refund of the sales and use taxes paid under Iowa Code chapter 423 for gas, electricity, water, or sewer utility services, goods, wares, or merchandise, or on services rendered, furnished, or performed to or for a contractor or subcontractor and used in the fulfillment of a written contract relating to the construction or equipping of a facility of the approved business. Taxes attributable to intangible property and furniture and furnishings shall not be refunded.

a. Filing a claim. To receive the refund, the approved business shall file a claim with the department of revenue as follows:

(1) The contractor or subcontractor shall state under oath, on forms provided by the department of revenue, the amount of sales or goods, wares, or merchandise, or services rendered, furnished, or performed, including water, sewer, gas, and electric utility services upon which sales or use tax has been paid prior to the project completion, and shall file the forms with the approved business before final settlement is made.

(2) The approved business shall, not more than 12 months following project completion, make application to the department of revenue for any refund of the amount of the sales and use taxes paid pursuant to Iowa Code chapter 423 upon any goods, wares, or merchandise, or services rendered, furnished, or performed, including water, sewer, gas, and electric utility services.

(3) The eligible business shall inform the department of revenue in writing within two weeks of project completion.

b. Racks, shelving, and conveyor equipment. If the project is the location, expansion, or modernization of a warehouse or distribution center, the approved business may be entitled to a refund of sales and use taxes attributable to racks, shelving, and conveyor equipment. The approved business shall, not more than 12 months following project completion, make written application to the department

for a refund. The application must include the refund amount being requested and documentation such as invoices or contracts which substantiate the requested amount. The department, in consultation with the department of revenue, will validate the refund amount and instruct the department of revenue to issue the refund.

The aggregate combined total amount of refunds and tax credits attributable to sales and use taxes on racks, shelving, and conveyor equipment issued by the department to businesses approved for high quality jobs program and enterprise zone program benefits shall not exceed $500,000 during a fiscal year. Tax refunds and tax credits will be issued on a first-come, first-served basis. If an approved business's application does not receive a refund or tax credits due to the $500,000 fiscal year limitation, the approved business's application shall be considered in the succeeding fiscal year.

68.4(2) *Corporate tax credit for certain sales taxes paid by third-party developer.* Pursuant to Iowa Code section 15.331C, the approved business may claim a corporate tax credit up to an amount equal to the sales and use taxes paid by a third-party developer under Iowa Code chapter 423 for gas, electricity, water, or sewer utility services, goods, wares, or merchandise, or on services rendered, furnished, or performed to or for a contractor or subcontractor and used in the fulfillment of a written contract relating to the construction or equipping of a facility of the approved business. Taxes attributable to intangible property and furniture and furnishings shall not be refunded.

Any tax credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until depleted, whichever occurs earlier. An approved business may elect to receive a refund of all or a portion of an unused tax credit.

a. Filing a claim. To receive the tax credit, the approved business shall file a claim with the department as follows:

(1) The third-party developer shall state under oath, on forms provided by the department of revenue, the amount of sales and use taxes paid and submit the forms to the approved business.

(2) The approved business shall, not more than 12 months following project completion, submit the completed forms to the department.

(3) In consultation with the department of revenue, the department shall issue a tax credit certificate in an amount equal to all or a portion of the sales and use taxes paid by a third-party developer under Iowa Code chapter 423 for gas, electricity, water, or sewer utility services, goods, wares, or merchandise, or on services rendered, furnished, or performed to or for a contractor or subcontractor and used in the fulfillment of a written contract relating to the construction or equipping of a facility of the approved business.

(4) The approved business shall not claim the tax credit provided in this subrule unless a tax credit certificate issued by the department is attached to the approved business's tax return for the tax year in which the tax credit is claimed. A tax credit certificate shall contain the approved business's name, address, tax identification number, the amount of the tax credit, and other information required by the department of revenue.

b. Racks, shelving, and conveyor equipment. If the project is the location, expansion, or modernization of a warehouse or distribution center, the approved business may claim a corporate tax credit up to the amount of sales and use taxes paid by a third-party developer and attributable to racks, shelving, and conveyor equipment. The approved business shall, not more than 12 months following project completion, make written application to the department for a tax credit. The application must include the tax credit amount being requested and documentation from the third-party developer such as invoices or contracts which substantiate the requested amount. The department, in consultation with the department of revenue, will confirm the tax credit amount and issue a tax credit certificate in an amount equal to all or a portion of the sales and use taxes attributable to racks, shelving, and conveyor equipment. The approved business shall not claim the tax credit provided in this subrule unless a tax credit certificate issued by the department is attached to the approved business's tax return for the tax year in which the tax credit is claimed. A tax credit certificate shall contain the approved business's name, address, tax identification number, the amount of the tax credit, and other information required by the department of revenue. Any tax credit in excess of the tax liability for the tax year may be

credited to the tax liability for the following seven years or until depleted, whichever occurs earlier. An approved business may elect to receive a refund of all or a portion of an unused tax credit.

The aggregate combined total amount of refunds and tax credits attributable to sales and use taxes on racks, shelving, and conveyor equipment issued by the department to businesses approved for high quality jobs program and enterprise zone program benefits shall not exceed $500,000 during a fiscal year. Tax refunds and tax credits will be issued on a first-come, first-served basis. If an approved business's application does not receive a refund or tax credits due to the $500,000 fiscal year limitation, the approved business's application shall be considered in the succeeding fiscal year.

68.4(3) *Value-added property tax exemption.* Pursuant to Iowa Code section 15.332, the community may exempt from taxation all or a portion of the actual value added by improvements to real property directly related to jobs created or retained by the location or expansion of the approved business and used in the operations of the approved business. The exemption may be allowed for a period not to exceed 20 years beginning the year the improvements are first assessed for taxation. For purposes of this subrule, improvements include new construction and rehabilitation of and additions to existing structures. The exemption shall apply to all taxing districts in which the real property is located. The community shall provide the department and the local assessor with a copy of the resolution adopted by its governing body which indicates the estimated value and duration of the authorized exemption.

68.4(4) *Investment tax credit.*

a. Claiming the investment tax credit. Pursuant to Iowa Code section 15.333, the approved business may claim an investment tax credit equal to a percentage of the new investment directly related to jobs created or retained by the start-up, location, expansion, or modernization of the approved business under the program. The tax credit shall be earned when the qualifying asset is placed in service.

(1) Five-year amortization period. The tax credit shall be amortized equally over a five-year period which the department will, in consultation with the approved business, define. The five-year amortization period will be specified in the agreement referenced in subrule 68.5(1). The tax credit shall be allowed against taxes imposed under Iowa Code chapter 422, division II, III, or V and against the moneys and credits tax imposed in Iowa Code section 533.24.

(2) Flow-through of tax credits. If the business is a partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501 or 501A and filing as a partnership for federal tax purposes, or estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit allowed. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings of the partnership, S corporation, limited liability company, cooperative organized under Iowa Code chapter 501or 501A and filing as a partnership for federal tax purposes, or estate or trust.

(3) Seven-year carryforward. A tax credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until depleted, whichever occurs first.

b. Investment qualifying for the tax credit. For purposes of this subrule, new investment directly related to jobs created or retained by the start-up, location, expansion or modernization of the approved business under the program means all of the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1, subsection 1, paragraphs *"e"* and *"j,"* purchased for use in the operation of the approved business.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the approved business.

(4) The annual base rent paid to a third-party developer by an approved business for a period equal to the term of the lease agreement but not to exceed the maximum term of the agreement referenced in subrule 68.5(1), provided the cumulative cost of the base rent payments for that period does not exceed the cost of the land and the third-party developer's costs to build or renovate the building for the approved business. Annual base rent shall be considered only when the project includes the construction of a new building or the major renovation of an existing building. The approved business shall enter into a lease agreement with the third-party developer for a minimum of five years.

Pursuant to subrule 68.4(9), the approved business shall not claim a tax credit above the amount defined in the final award documentation.

c. Refunds.

(1) Refund of unused tax credit. Subject to prior approval by the department, in consultation with the department of revenue, an approved business whose project primarily involves the production of value-added agricultural products or uses biotechnology-related processes may elect to receive a refund of all or a portion of an unused tax credit.

(2) IRS Section 521. For purposes of this paragraph, an approved business includes a cooperative, described in Section 521 of the Internal Revenue Code, that is not required to file an Iowa corporate income tax return and whose project primarily involves the production of ethanol.

(3) Refund of unused tax credit procedures. For application to receive a refund of all or a portion of an unused tax credit, the following procedures apply:

1. Department approval required. The department will determine whether an approved business's project primarily involves the production of value-added agricultural products or uses biotechnology-related processes.

2. Application for a tax credit certificate. The approved business shall apply for a tax credit certificate using the form provided by the department. Requests for tax credit certificates will be accepted between May 1 and May 15 of each fiscal year. Only those approved businesses that have been issued final award documentation pursuant to subrule 68.4(9) before the May 1 filing date may apply for a tax credit certificate.

The department shall require the cooperative, as described in Section 521 of the Internal Revenue Code, to submit a list of members whom the cooperative wishes to receive a tax credit certificate for their prorated share of ownership. The cooperative shall submit its list in a computerized electronic format that is compatible with the system used or designated by the department. For each cooperative member approved for a tax credit certificate, the computerized list shall, at a minimum, include the name, address, social security number or taxpayer identification number, business telephone number and ownership percentage, carried out to six decimal places. The cooperative shall also submit a total dollar amount of the unused investment tax credit for which the cooperative's members are requesting a tax credit certificate.

(4) Issuance of tax credit certificates. The department shall not issue tax credit certificates to approved businesses in the high quality jobs program and the enterprise zone program which total more than $4 million during a fiscal year. If the department receives applications for tax credit certificates in excess of $4 million, the applicants shall receive certificates for a prorated amount. In such a case, the tax credit requested by an approved business will be prorated based upon the total dollar amount of requested tax credit certificates received during the fiscal year. This proportion will be applied to the amount requested by each approved business to determine the amount of the tax credit certificate that will be distributed to each business for the fiscal year. For example, if an approved business submits a request in the amount of $1 million and the total amount of requested tax credit certificates equals $8 million, the business will be issued a tax credit certificate in the amount of $500,000 ($4 million / $8 million = 50% × $1 million = $500,000). The department will issue tax credit certificates within a reasonable period of time following the May 15 application deadline.

(5) Claiming the tax credit certificate. Tax credit certificates shall not be valid until the tax year following the date the final award documentation was issued. The tax credit certificates shall not be transferred except in the case of a cooperative as described in Section 521 of the Internal Revenue Code whose approved project primarily involves the production of ethanol. For such cooperative, the individual members of the cooperative are approved to receive the tax credit certificates. The approved business may not claim a tax credit refund unless a tax credit certificate issued by the department is attached to the taxpayer's tax return for the tax year in which the tax credit refund is claimed.

(6) Carryforward. An approved business may apply for a tax credit certificate once each year for up to seven years after the final award documentation is issued or until the approved business's unused tax credit is depleted, whichever occurs first. For example, an approved business which receives its final award documentation in October 2005 and has an investment tax credit of $1 million may apply for a tax

credit certificate in May 2006. If, because of proration of the $4 million of available refundable credits for the fiscal year, the business is awarded a tax credit certificate in the amount of $300,000, the business may claim the $300,000 refund and carry forward the unused investment tax credit of $700,000 up to seven years or until the credit is depleted, whichever occurs first.

68.4(5) *Insurance premium tax credit.* Pursuant to Iowa Code section 15.333A, the approved business may claim an insurance premium tax credit equal to a percentage of the new investment directly related to jobs created or retained by the start-up, location, expansion, or modernization of the approved business under the program.

a. Claiming the tax credit. The tax credit shall be earned when the qualifying asset is placed in service. The tax credit shall be amortized equally over a five-year period which the department will, in consultation with the eligible business, define. The five-year amortization period shall be specified in the agreement referenced in subrule 68.5(1). The tax credit shall be allowed against taxes imposed under Iowa Code chapter 432. A tax credit in excess of the tax liability for the tax year may be credited to the tax liability for the following seven years or until depleted, whichever occurs first.

b. Investment qualifying for the tax credit. For purposes of this subrule, new investment directly related to jobs created or retained by the start-up, location, expansion or modernization of the approved business under the program means all of the following:

(1) The cost of machinery and equipment, as defined in Iowa Code section 427A.1, subsection 1, paragraphs *"e"* and *"j,"* purchased for use in the operation of the approved business.

(2) The purchase price of real property and any buildings and structures located on the real property.

(3) The cost of improvements made to real property which is used in the operation of the approved business.

(4) The annual base rent paid to a third-party developer by an approved business for a period equal to the term of the lease agreement but not to exceed the maximum term of the agreement referenced in subrule 68.5(1), provided the cumulative cost of the base rent payments for that period does not exceed the cost of the land and the third-party developer's costs to build or renovate the building for the approved business. Annual base rent shall be considered only when the project includes the construction of a new building or the major renovation of an existing building. The approved business shall enter into a lease agreement with the third-party developer for a minimum of five years.

Pursuant to subrule 68.4(9), the approved business shall not claim a tax credit above the amount defined in the final award documentation.

68.4(6) *Research activities credit.* Pursuant to Iowa Code section 15.335, the approved business may claim a corporate tax credit for increasing research activities in Iowa during the period the approved business is participating in the program.

a. Calculation. The credit equals the sum of the following:

(1) Six and one-half percent of the excess of qualified research expenses during the tax year over the base amount for the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

(2) Six and one-half percent of the basic research payments determined under Section 41(e)(1)(A) of the Internal Revenue Code during the tax year based upon the state's apportioned share of the qualifying expenditures for increasing research activities.

The state's apportioned share of the qualifying expenditures for increasing research activities is a percent equal to the ratio of qualified research expenditures in this state to total qualified research expenditures.

b. Alternate calculation. In lieu of the credit amount computed in subparagraph 68.4(6)*"a"*(1), the approved business may elect to compute the credit amount for qualified research expenses incurred in Iowa in a manner consistent with the alternative incremental credit described in Section 41(c)(4) of the Internal Revenue Code. The taxpayer may make this election regardless of the method used for the taxpayer's federal income tax. The election made under subrule 68.4(6) is for the tax year and the taxpayer may use either the method outlined in paragraph *"a"* or in this paragraph for any subsequent year.

For purposes of this alternate credit computation method, the credit percentages applicable to the qualified research expenses described in clauses (i), (ii), and (iii) of Section 41(c)(4)(A) of the Internal Revenue Code are 1.65 percent, 2.20 percent, and 2.75 percent, respectively.

c. Additional research activities credit. The credit allowed in this subrule is in addition to the credit authorized in Iowa Code sections 422.10 and 422.33(5). However, if the alternative credit computation method is used in Iowa Code section 422.10 or 422.33(5), the credit allowed in this subrule shall also be computed using that method.

d. Flow-through of tax credits. If the eligible business is a partnership, S corporation, limited liability company, or estate or trust electing to have the income taxed directly to the individual, an individual may claim the tax credit allowed. The amount claimed by the individual shall be based upon the pro rata share of the individual's earnings from the partnership, S corporation, limited liability company, or estate or trust.

e. Definitions. For purposes of this subrule, "base amount," "basic research payment," and "qualified research expense" mean the same as defined for the federal credit for increasing research activities under Section 41 of the Internal Revenue Code except that, for the alternative incremental credit, such amounts are for research conducted within Iowa. For purposes of this subrule, "Internal Revenue Code" means the Internal Revenue Code in effect on January 31, 2005.

f. Refunds. Any credit in excess of the tax liability for the taxable year shall be refunded with interest computed under Iowa Code section 422.25. In lieu of claiming a refund, a taxpayer may elect to have the overpayment shown on its final, completed return credited to the tax liability for the following year.

g. Renewable energy generation components. For purposes of this subrule, "research activities" includes the development and deployment of innovative renewable energy generation components manufactured or assembled in Iowa. A renewable energy generation component will no longer be considered innovative when more than 200 megawatts of installed effective nameplate capacity has been achieved. Research activities credits awarded under this program and the enterprise zone program for innovative renewable energy generation components shall not exceed $1 million.

68.4(7) *Maximum tax incentives available.* Tax incentives and assistance awarded under this program are based upon the number of jobs created or retained that pay the qualifying wage threshold for HQJP as established in 261—Chapter 174 and as defined in 261—Chapter 173 and the amount of qualifying investment. The maximum possible award is based on the following schedule:

a. No high quality jobs are created or retained but economic activity is furthered by the qualifying investment. For purposes of this paragraph, "economic activity" means a modernization project which will result in increased skills and wages for the current employees; a project involving retained jobs; or a project that involves a waiver, granted by the board pursuant to rule 261—174.6(15E,15G,83GA,SF344), of the qualifying wage threshold calculation if the reason for the waiver is that damages were sustained as a result of a natural disaster in a presidentially declared disaster area.

(1) Less than $100,000 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 1 percent.
2. Reserved.

(2) $100,000 to $499,999 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 1 percent.
2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

(3) $500,000 or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 1 percent.
2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.
3. Research activities credit.

b. 1 to 5 high quality jobs are created or retained.

(1) Less than $100,000 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 2 percent.

2. Reserved.

(2) $100,000 to $499,999 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 2 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

(3) $500,000 or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 2 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

c. 6 to 10 high quality jobs are created or retained.

(1) Less than $100,000 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 3 percent.

2. Reserved.

(2) $100,000 to $499,999 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 3 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

(3) $500,000 or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 3 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

d. 11 to 15 high quality jobs are created or retained.

(1) Less than $100,000 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 4 percent.

2. Reserved.

(2) $100,000 to $499,999 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 4 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

(3) $500,000 or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 4 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

e. 16 to 30 high quality jobs are created or retained.

(1) Less than $100,000 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 5 percent.

2. Reserved.

(2) $100,000 to $499,999 in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 5 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

(3) $500,000 or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 5 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

f. 31 to 40 high quality jobs are created or retained.

(1) $10 million or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 6 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

4. Value-added property tax exemption.

(2) Reserved.

g. 41 to 60 high quality jobs are created or retained.

(1) $10 million or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 7 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

4. Value-added property tax exemption.

(2) Reserved.

h. 61 to 80 high quality jobs are created or retained.

(1) $10 million or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 8 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

4. Value-added property tax exemption.

(2) Reserved.

i. 81 to 100 high quality jobs are created or retained.

(1) $10 million or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 9 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

4. Value-added property tax exemption.

(2) Reserved.

j. 101 or more high quality jobs are created or retained.

(1) $10 million or more in qualifying investment.

1. Investment tax credit or insurance premium tax credit of up to 10 percent.

2. Sales and use tax refund or corporate tax credit for certain sales taxes paid by third-party developer, or both, if applicable.

3. Research activities credit.

4. Value-added property tax exemption.

(2) Reserved.

68.4(8) *Award limitations.* Each calendar year, the department shall not approve more than $3.6 million worth of investment tax credits and insurance premium tax credits for projects with qualifying investments of less than $1 million. Tax credits subject to this limitation will be awarded on a first-come, first-served basis.

68.4(9) *Final award amounts.* Rescinded IAB 7/15/09, effective 7/1/09.

[**ARC 7557B**, IAB 2/11/09, effective 3/18/09; **ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—68.5(81GA,HF868) Agreement, compliance and repayment provisions. Rescinded IAB 7/4/07, effective 6/15/07.

These rules are intended to implement Iowa Code sections 15.326 to 15.336 as amended by 2009 Iowa Acts, Senate File 344.

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CHAPTER 69
LOAN AND CREDIT GUARANTEE PROGRAM

261—69.1(15E,81GA,HF868) Purpose. The purpose of the loan and credit guarantee program is to create incentives and assistance to increase the flow of private capital to targeted industry businesses, microenterprises, and other qualified businesses, to promote industrial modernization and technology adoption, to encourage the retention and creation of jobs, and to encourage the export of goods and services sold by Iowa businesses in national and international markets. The department may invest up to 10 percent of the assets of the loan and credit guarantee fund or $500,000, whichever is higher, to provide assistance to microenterprises.

261—69.2(15E,81GA,HF868) Definitions.

"Act" means Iowa Code sections 15E.221 to 15E.227 as amended by 2005 Iowa Acts, House File 868.

"Board" or "IDED board" means the Iowa economic development board established in Iowa Code section 15.103 as amended by 2005 Iowa Acts, House File 868, section 4, and composed of 15 voting members and 7 ex officio nonvoting members.

"Committee" means the loan and credit guarantee committee described in 261—subrule 1.3(4) and created by the board to review applications requesting assistance from the loan and credit guarantee program and make funding recommendations to the board.

"Department" or *"IDED"* means the Iowa department of economic development.

"Financial institution" means a state bank as defined in Iowa Code section 524.103, subsection 33, a state bank chartered under the laws of any other state, a national banking association, a trust company, a federally chartered savings and loan association, an out-of-state state-chartered savings bank, a financial institution chartered by the federal home loan bank board, a non-Iowa chartered savings and loan association, an association incorporated or authorized to do business under Iowa Code chapter 534, or a production credit association or such other financial institution as defined by the department for purposes of this chapter.

"Microenterprise" means a business providing services with five or fewer full-time equivalent employee positions, and located in a municipality with a population under 50,000 that is not contiguous to a municipality with a population of 50,000 or more.

"Program" means the loan and credit guarantee program established in the Act.

"Qualified business" means an existing or proposed business entity with an annual average number of employees not exceeding 200 employees. "Qualified business" does not include businesses engaged primarily in retail sales, real estate, or the provision of health care or other professional services. "Qualified business" includes professional services businesses that provide services to targeted industry businesses or other entities. To be considered a qualified business, a professional services business must derive a majority of its revenue from targeted industry businesses.

"Targeted industry business" means an existing or proposed business entity, including an emerging small business or qualified business which is operated for profit and which has a primary business purpose of doing business in at least one of the targeted industries designated by the department, which include life sciences, software and information technology, advanced manufacturing, value-added agriculture, and any other industry designated as a targeted industry by the board.

261—69.3(15E,81GA,HF868) Application and review process. The department, with the advice of the loan and credit guarantee committee, shall develop and make available a standardized application pertaining to the issuance of loan and credit guarantees. Subject to the availability of funds, the loan and credit guarantee committee will review applications and make recommendations to the board pertaining to the approval of loan and credit guarantee awards.

69.3(1) Each participating financial institution shall identify and underwrite potential lending opportunities with qualified businesses, microenterprises, and targeted industry businesses. Upon determination by the financial institution that the business meets the financial institution's underwriting

criteria, subject to the approval of a loan and credit guarantee, the financial institution shall submit a loan and credit guarantee application and the underwriting information to the department.

69.3(2) It shall be the responsibility of the financial institution and the qualified business, microenterprise, or targeted industry business to submit a complete application. The department shall determine when an application is complete. Once the department has determined that an application is complete, the committee and the board shall consider the application as expeditiously as possible.

69.3(3) The department may develop an application procedure to allow a qualified business, microenterprise, or targeted industry business to apply directly to the department for a preliminary guarantee determination. A preliminary guarantee determination may be issued by the department, following board approval, subject to the qualified business's, microenterprise's, or targeted industry business's securing a commitment for financing from a financial institution.

261—69.4(15E,81GA,HF868) Application approval or rejection. Upon approval of an application, the department shall issue a loan and credit guarantee agreement with a financial institution outlining the terms and conditions upon which the loan will be guaranteed.

69.4(1) No guarantee shall become effective until the required fees have been paid. Such payment, along with an executed loan authorization, shall indicate the financial institution's acceptance of the terms of the loan authorization.

69.4(2) In the event the board rejects an application, the financial institution and the borrower will be sent notice, including reasons for the rejection.

261—69.5(15E,81GA,HF868) Terms and conditions. A loan and credit guarantee provided to a financial institution for a qualified business, microenterprise, or targeted industry business shall not exceed $1 million. Loan and credit guarantees provided under the program to more than one financial institution for a single qualified business, microenterprise, or targeted industry business shall not exceed $10 million. A single qualified business, microenterprise, or targeted industry business may have multiple guarantees with multiple financial institutions. The aggregate amount of loan or credit guarantees provided to financial institutions for any single qualified business, microenterprise, or targeted industry business shall not exceed $10 million.

69.5(1) A loan and credit guarantee provided under the program shall be for eligible project costs. Eligible project costs include expenditures for production equipment and machinery, land and real estate, working capital for operations and export transactions, research and development, marketing, engineering and architectural fees, and such other costs as the department may designate.

69.5(2) The loan and credit guarantee provided under the program shall be negotiated on a case-by-case basis and in no case shall exceed more than 50 percent of the amount to be loaned to the qualified business, microenterprise, or targeted industry business by the financial institution for the project as described in the loan and credit guarantee application.

69.5(3) Interest rate and term of the loan to be secured shall be agreed upon between the financial institution and the borrower, provided that no guarantee exceeds 15 years.

69.5(4) Repayment of a guaranteed loan shall be secured by such collateral as the department deems prudent.

69.5(5) The covenants and requirements of the loan shall be established by the financial institution and department in accordance with prudent lending practices.

261—69.6(15E,81GA,HF868) Administrative costs and program fees. The department shall establish fees for participation in the loan and credit guarantee program.

69.6(1) The department shall charge a nonrefundable application fee for a loan and credit guarantee. The department shall set the application fee annually and include the fee information in the application materials for the loan and credit guarantee program. This fee will be payable upon submission of an application for a loan and credit guarantee from a financial institution or a qualified business, microenterprise, or targeted industry business and shall not exceed $1,000.

69.6(2) Upon the approval of a loan and credit guarantee application, the department shall charge a fee for authorization of the loan or credit guarantee. The fee shall be 2.5 percent of the amount of funds to be guaranteed under the program. No loan and credit guarantee agreement will be executed until the fee is received by the department.

69.6(3) For a line of credit, the authorization fee shall be one-half percent per year renewable annually for a period not to exceed five years. The guarantee will automatically expire if the fee is not submitted upon renewal of the line of credit.

261—69.7(15E,81GA,HF868) Administration of guarantees. A preliminary commitment issued by the department shall be effective for 90 days from the date of issuance. If the contingencies outlined in the preliminary commitment are not met within 90 days, the preliminary commitment will be void.

69.7(1) A loan and credit guarantee agreement shall be executed between a financial institution, the borrower and the department. These rules and applicable state laws and regulations shall be part of the agreement. The loan and credit guarantee agreement shall include, but is not limited to, the following:

a. Provisions setting forth the responsibilities of the financial institution to prudently underwrite and service insured loans in such a manner as would be the normal and customary practice of a prudent lender making or servicing a loan.

b. A requirement that the financial institution notify the department in writing within 5 business days after a borrower's payment is 30 days late and within 15 business days of any other default or event or condition which indicates the loan may be difficult to collect in full. Upon default of the loan, the financial institution, in consultation with the department, shall take such action as may be prudent, including foreclosing on and liquidating collateral.

c. The department may, at its discretion, cancel or reduce a loan or credit guarantee if the financial institution demonstrates instances of fraud or gross malfeasance under the loan and credit guarantee agreement.

d. Awards may be conditioned upon commitment of other sources of funds necessary to complete the project or upon other matters as determined appropriate by the department.

69.7(2) The financial institution and borrower must execute and return the loan and credit guarantee agreement to the department within the time period specified by the department in the agreement. Failure to do so may be cause for the department to terminate the loan and credit guarantee.

69.7(3) Any substantive change to a loan and credit guarantee agreement, such as time extensions, budget revisions and significant alteration of the funded project that change the scope, location, objectives or scale of the approved project or changes in terms of credit, shall be considered a request for an amendment. Amendments must be requested in writing by the financial institution. Amendments are not considered valid until approved by the committee and the department and confirmed in writing by IDED following the procedure specified in the contract between the recipient and IDED.

69.7(4) Financial institutions shall comply with these rules, with any provisions of the Iowa Code governing activities performed under this program and with applicable local regulations.

261—69.8(15E,83GA,SF344) Applicability of LCG program after July 1, 2009.

69.8(1) Effective July 1, 2009, the LCG program is rescinded by 2009 Iowa Acts, Senate File 344, section 9.

69.8(2) For awards made prior to July 1, 2009, the rules of 261—Chapter 69 shall govern for purposes of loan guarantee contract administration and closeout of contracts. A contract amendment is not allowable if the result of the amendment is to increase the benefits available.

This rule is intended to implement 2009 Iowa Acts, Senate File 344.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code sections 15E.221 to 15E.227 and 2003 Iowa Acts, First Extraordinary Session, chapter 2, section 69, and 2005 Iowa Acts, House File 868.

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CHAPTER 73
Reserved

CHAPTER 74
GROW IOWA VALUES FINANCIAL ASSISTANCE PROGRAM

261—74.1(83GA,SF344) Purpose and administrative procedures.

74.1(1) *Purpose.* The department shall establish and administer a grow Iowa values financial assistance program for purposes of providing financial assistance from the fund to applicants. The financial assistance shall be provided from moneys credited to the grow Iowa values fund and not otherwise obligated or allocated pursuant to 2009 Iowa Acts, Senate File 344.

74.1(2) *Program funding components.* The program shall consist of the following components:

a. 130 percent wage component.

b. 100 percent wage component.

c. Entrepreneurial component.

d. Infrastructure component.

e. Value-added agriculture component.

f. Disaster recovery component.

74.1(3) *Fiscal impact.* In making awards of financial assistance from the 130 percent wage component and the 100 percent wage component, the department shall calculate the fiscal impact ratio. In reviewing each application to determine the amount of financial assistance to award, the board shall consider the appropriateness of the award to the fiscal impact ratio of the project and to other factors deemed relevant by the board.

74.1(4) *Administrative procedures.* The grow Iowa values financial assistance program is subject to the requirements of the department's rules located in 261—Part VII, additional application requirements and procedures, and 261—Part VIII, legal and compliance. Part VII and Part VIII include standard definitions; standard program requirements; wage, benefit and investment requirements; application review and approval procedures; contracting; contract compliance and job counting; and annual reporting requirements.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—74.2(83GA,SF344) 130 percent wage component.

74.2(1) *Eligibility.* In order to qualify for financial assistance under this component of the program, a business shall meet all of the following requirements:

a. The business shall create or retain jobs as part of a project, and the jobs created or retained shall meet one of the following requirements:

(1) If the business is creating jobs, the business shall demonstrate that the jobs will pay at least 100 percent of the qualifying wage threshold at the start of the project completion period, at least 130 percent of the qualifying wage threshold by the project completion date, and at least 130 percent of the qualifying wage threshold until the maintenance period completion date.

(2) If the business is retaining jobs, the business shall demonstrate that the jobs retained will pay at least 130 percent of the qualifying wage threshold throughout both the project completion period and the maintenance period.

b. The business shall provide a sufficient package of benefits to each employee holding a created or retained job.

c. The business shall demonstrate that the jobs created or retained will have a sufficient impact on state and local government revenues as determined by the department after calculating the fiscal impact ratio of the project.

d. The business shall not be a retail business or a business where entrance is limited by a cover charge or membership requirement.

74.2(2) *Sufficient benefits credit.* A business providing a sufficient package of benefits to each employee holding a created or retained job shall qualify for a credit against any of the 130 percent qualifying wage threshold requirement.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—74.3(83GA,SF344) 100 percent wage component. In order to qualify for financial assistance under this component of the program, a business shall meet all of the following requirements:

74.3(1) The business shall create or retain jobs as part of a project, and the jobs created or retained shall meet one of the following qualifying wage thresholds:

a. If the business is creating jobs, the business shall demonstrate that the jobs created will pay at least 100 percent of the qualifying wage threshold at the start of the project completion period, by the project completion date, and until the maintenance period completion date.

b. If the business is retaining jobs, the business shall demonstrate that the jobs retained will pay at least 100 percent of the qualifying wage threshold throughout both the project completion period and the maintenance period.

74.3(2) The business shall provide a sufficient package of benefits to each employee holding a created or retained job.

74.3(3) The business shall demonstrate that the jobs created or retained will have a sufficient impact on state and local government revenues as determined by the department after calculating the fiscal impact ratio of the project.

74.3(4) The business shall not be a retail business or a business where entrance is limited by a cover charge or membership requirement.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—74.4(83GA,SF344) Entrepreneurial component.

74.4(1) *Purpose.* The purpose of this component is to encourage the development of early-stage businesses in conjunction with the delivery of a financial assistance program.

74.4(2) *Definitions.* In addition to the standard definitions in 261—Chapter 173, the following definitions shall apply to this component:

"Early-stage business" means a business that has been competing in a particular industry for three years or less.

"Eligible applicant" means a business that has consulted with and obtained a letter of endorsement from either a business accelerator approved by the department or from an entrepreneurial development organization recognized by the department.

"Eligible business" means an early-stage business that is developing a new product or technology.

74.4(3) *Eligibility.* In order to qualify for financial assistance under the entrepreneurial component of the program, a business shall meet all of the following requirements:

a. In order to be eligible for assistance, the business, or proposed business, must be located in the state of Iowa.

b. The business shall be an early-stage business.

c. If the business is a sole proprietorship or a partnership, all applicable business owners must apply. If the business is a limited liability company, a limited liability partnership, or a corporation, the application must be submitted and signed by an individual who has been authorized by the business to do so.

d. The business owner or owners (or appropriate individual(s) in a limited liability company, limited liability partnership or corporation) must consult with and obtain a letter of endorsement from either a business accelerator approved by the department or from an entrepreneurial development organization recognized by the department.

e. The individual or business must have a business plan which details the business's growth strategy, management team, production/management plan, marketing plan, financial plan, and other standard elements of a business plan.

74.4(4) *Local match not required.* A business applying for financial assistance under the entrepreneurial component is eligible for financial assistance regardless of whether the business has received matching funds from a city or county.

74.4(5) *Funding priorities.* In awarding financial assistance under the entrepreneurial component of the program, the department and the board shall give priority to businesses in those sectors of the Iowa economy with the greatest potential for growth and expansion. Sectors having such potential include but

are not limited to biotechnology, recyclable materials, software development, computer-related products, advanced materials, and advanced manufacturing.

74.4(6) *Financial assistance.* An applicant may apply to the department for financial assistance to assist with the applicant's early-stage business growth. The applicant may request up to $250,000 for early-stage growth activities to be used for business expenses and to leverage conventional financing from commercial lenders or private investors. Assistance will generally be made in staged investments with amounts to be determined by company development, growth, and defined milestones. The assistance under this program is limited to 50 percent or less of the total original capitalization, if a new business, or total project costs, if an existing business. Funds may be used to purchase machinery, equipment, or software or for working capital needs or other business expenses deemed reasonable and appropriate by the department. Awards will be in the form of a loan, royalty agreement, or other form of an equity-like investment. A single recipient is limited to $250,000 in total financial assistance.

74.4(7) *Technical assistance.* Applicants may apply for assistance in paying for consulting or other third-party technical assistance either in conjunction with the request for financial assistance or in a separate application. Applications submitted that are not in conjunction with a request for financial assistance must demonstrate financial need for the technical assistance. Financial need will be determined by the department based on review of the applicant's financial statements, narrative submitted by the applicant outlining the financial need, and other documentation as requested by the department. Awards will be in the form of a grant, loan, royalty agreement, or other form of an equity-like investment. Technical assistance of this nature is limited to no more than $25,000 per applicant.

74.4(8) *Application process.* Applications must be submitted in the format required by the department. Applications, the business plan, and related material shall be submitted online or by mail to the department at the address listed in 261—subrule 175.2(7).

74.4(9) *Review criteria.*

a. Applications will first be reviewed for completeness. If additional information is required, the program staff shall send the applicant notice to submit the additional needed information. The applicant shall submit the requested information within a reasonable time period in order to ensure further action on the request.

b. Applications will then be reviewed for content of the business plan and to evaluate the business's viability and potential for growth. The department may consult with the business accelerators or other knowledgable agencies or individuals as a part of the review process.

c. The following items will be reviewed:

(1) Type of business.

1. Highest priority will be given to businesses in sectors of the Iowa economy with the greatest start-up and growth potential for Iowa, including but not limited to:

- Biotechnology (including drugs and pharmaceuticals and value-added agricultural products);
- Recyclable materials;
- Software development and computer-related products;
- Advanced materials; and
- Advanced manufacturing.

2. Assistance may be provided to industries other than those listed in paragraph "1" above; however, the applicant shall provide strong rationale regarding how that industry diversifies, strengthens or otherwise enhances Iowa's economy. Eligibility may be established by an industry other than those listed if that industry can provide rationale regarding the industry's benefit to Iowa's economic base. Rationale that is provided will be reviewed by the department staff to determine eligibility as a targeted industry. Factors that will be considered in determining an industry's benefit to Iowa's economic base include:

- The majority of the products produced by the industry are exported out of Iowa;
- The inputs for the products produced in the industry are raw materials available in Iowa or are provided by Iowa suppliers;
- The goods produced by the industry diversify Iowa's economy;

- The goods produced by the industry resulted in, or will result in, a decrease in the importation of foreign-made goods into the United States;
- The industry shows potential for future growth; and
- The functions of the industry do not produce harmful effects for Iowa's natural environment.

Businesses engaged in retail sales, personal services, consulting, franchises, the provision of health care or other professional services, or the distribution of products or services will not be considered targeted industries and are not eligible for the program.

(2) Management team and management expertise. Factors considered for this criterion are whether the applicant(s) has a background (including education, training, work experience, and other factors) that will be helpful and useful in the business in question. The department will also consider the degree to which the applicant's background is fully documented.

(3) Business capitalization. Factors considered for this criterion are the original sources of financing for the business. Although all projects must have at least 50 percent of their financing from sources other than the entrepreneurial component, the department will give preference to those applications in which the other sources of financing are higher than 50 percent.

(4) Strength of business plan. The strength of the business plan is the most important factor in the evaluation of applications. Factors considered for this criterion are the quality of the business plan and how well it addresses all elements of the business, such as:

1. A description of the company and the overall industry;
2. The product and production plan;
3. The market, competition, and the marketing strategy;
4. The management team and business operation;
5. A well-defined project time line;
6. Patent issues (if applicable), critical risks and problems; and
7. Financial information and plan.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—74.5(83GA,SF344) Infrastructure component.

74.5(1) *Eligibility.* In order to qualify for financial assistance under the infrastructure component of the program, a business or community shall be engaged in a physical infrastructure project. For purposes of this component, "physical infrastructure project" means a project that creates necessary infrastructure for economic success throughout Iowa, provides the foundation for the creation of jobs, and involves the investment of a substantial amount of capital. Physical infrastructure projects include but are not limited to projects involving any mode of transportation; public works and utilities such as sewer, water, power, or telecommunications; physical improvements that mitigate, prevent, or eliminate environmental contamination; and other similar projects deemed to be physical infrastructure by the department.

74.5(2) *Local match not required.* A business applying for financial assistance under the infrastructure component is eligible for financial assistance regardless of whether the business has received matching funds from a city or county.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—74.6(83GA,SF344) Value-added agriculture component.

74.6(1) *Purpose.* The purpose of this component is to encourage the increased utilization of agricultural commodities produced in this state. The component shall assist in efforts to revitalize rural regions of this state by committing resources to provide financial assistance to new or existing value-added production facilities.

74.6(2) *Definitions.* In addition to the standard definitions located in 261—Chapter 173, the following definitions apply to the value-added agriculture component:

"Agricultural biomass industry" means businesses that utilize agricultural commodity crops, agricultural by-products, or animal feedstock in the production of chemicals, protein products, or other high-value products.

"Agricultural biotechnology industry" means businesses that utilize scientifically enhanced plants or animals that can be raised by producers and used in the production of high-value products.

"Agriculture" means the science, art, and business of cultivating the soil, producing crops and raising livestock.

"Alternative energy industry" means businesses involved in the production of ethanol, including gasoline with a mixture of 70 percent or more ethanol, biodiesel, biomass, or hydrogen or in the production of wind energy.

"Committee" means the renewable fuels and coproducts advisory committee established pursuant to Iowa Code section 159A.4.

"Coordinator" means the administrative head of the office of renewable fuels and coproducts appointed by the department of agriculture and land stewardship as provided in Iowa Code section 159A.3.

"Coproduct" means a product other than a renewable fuel which at least in part is derived from the processing of agricultural commodities and which may include corn gluten feed, distillers grain, solubles, or a feed supplement, or can be used as livestock feed.

"Farming" means the cultivation of land for the production of agricultural crops, the raising of poultry, the production of eggs, the production of milk, the production of fruit or other horticultural crops, grazing or the production of livestock. "Farming" shall not include the production of timber, forest products, nursery products, or sod; and "farming" shall not include a contract where a processor or distributor of farm products or supplies provides spraying, harvesting or other farm services.

"Fund" means the renewable fuels and coproducts fund established pursuant to Iowa Code section 159A.7.

"Innovative" means a new or different agricultural product or a method of processing agricultural products which is an improvement over traditional methods in a new, different, or unusual way.

"Livestock production operations" means the production, feeding and marketing of livestock, poultry and aquaculture. "Livestock production operations" includes, but is not limited to, beef and dairy cattle, swine, sheep, goat, poultry, turkey and equine operations. "Livestock production operations" also includes nontraditional agricultural operations such as ostrich, fallow deer, rabbit, fish and other aquaculture.

"Office" means the office of renewable fuels and coproducts created pursuant to Iowa Code section 159A.3.

"Organic products" means Iowa-grown or Iowa-raised agricultural products as defined by 21—Chapter 47, Iowa organic program.

"Person" means individual, corporation, limited liability company, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

"Producer-owned, value-added business" means a person who holds an equity interest in the agricultural business and is personally involved in the production of crops or livestock on a regular, continuous, and substantial basis.

"Renewable fuel" means an energy source at least in part derived from an organic compound, capable of powering machinery, including an engine or power plant. "Renewable fuel" includes but is not limited to ethanol-blended or soydiesel fuel.

"Renewable fuels and coproducts activities" means either of the following:

1. The research, development, production, promotion, marketing, or consumption of renewable fuels and coproducts.

2. The research, development, transfer, or use of technologies which directly or indirectly increases the supply or demand of renewable fuels and coproducts.

"Rural region" means any geographic area which is predominantly rural in nature, that is, having a relatively low population density and where agriculture is the predominant economic activity.

"Soydiesel fuel" means a fuel made of processed soybean oil which is mixed with diesel fuel, the mixture being a minimum of 20 percent processed soybean oil.

"Value-added product" means a product which, through a series of activities or processes, can be sold at a higher price than its original purchase price.

74.6(3) *Eligibility.* In order to qualify for financial assistance under the value-added agriculture component of the program, a business shall be a production facility engaged in the process of adding

value to agricultural products. Projects considered eligible under this component include but are not limited to innovative agricultural products and processes, innovative and new renewable fuels, agricultural biotechnology, biomass and alternative energy production, and organic products and emerging markets. Financial assistance is available for project development as well as project creation.

a. Innovative agricultural products and processes. An application based on this component shall be considered if either of the following applies:

(1) The business will produce a product derived from an agricultural commodity, if the product is not commonly produced in Iowa from an agricultural commodity; or

(2) The business will utilize a process to produce a product derived from an agricultural commodity, if the process is not commonly used in Iowa to produce the product.

For purposes of this paragraph, a product is "not commonly produced" and a process is "not commonly used" if the product or process is not usually, generally, or ordinarily produced or processed in Iowa.

b. Innovative and new renewable fuels. Applications for renewable fuel and ethanol production shall be considered by the department for funding. Applications based on ethanol fuel production must meet the following criteria to be considered for funding:

(1) All fermentation, distillation, and dehydration of the ethanol occurs at the proposed facility.

(2) The ethanol produced at the proposed facility is at least 190 proof and is denatured. However, if the facility markets the ethanol for further refining, the facility must demonstrate that the refiner produces at least 190 proof ethanol from the ethanol purchased from the facility.

c. Agricultural biotechnology, biomass and alternative energy. Agricultural business facilities in the agricultural biotechnology industry, agricultural biomass industry, and alternative energy industry are eligible for program assistance.

d. Organic products and emerging markets. Facilities that add value to Iowa agricultural commodities through further processing and development of organic products and emerging markets are eligible for program assistance.

e. Project development assistance. The department, at its discretion, may also provide funding for project development related to targeted industries or proposed projects under this program. Feasibility studies and basic research are not eligible for assistance under this program.

f. Project creation assistance. This option is for projects that eventually could be eligible for funding within other value-added agriculture component funding areas.

(1) Any person is eligible to apply, except educational or research institutions. However, an educational or research institution may be a partner to an eligible applicant.

(2) The evaluation process will focus on the application of new technology and knowledge to agricultural products and processing and will be based upon the degree to which:

1. The resulting business has potential to increase utilization of agricultural commodities in this state; and

2. The resulting business has potential to increase value-added economic activities within this state.

74.6(4) *Ineligible projects.*

a. The department shall not provide financial assistance to support a value-added production facility if the facility or a person owning a controlling interest in the facility has, in the previous five years, demonstrated a continuous and flagrant disregard for the health and safety of its employees or the quality of the environment.

b. The department shall not approve an application for assistance under this component to refinance an existing loan.

c. The department shall not directly award financial assistance to support an activity directly related to farming as defined in Iowa Code section 9H.1, including the establishment or operation of a livestock production operation, regardless of whether the activity is related to a renewable fuel production facility.

d. An applicant may not receive more than one award under this program for a single project. However, previously funded projects may receive an additional award(s) if the applicant demonstrates

that the funding is to be used for a significant expansion of the project, a new project, or a project which results from previous project development assistance.

e. The board and the department shall not award financial assistance under the value-added agriculture component in an amount exceeding 50 percent of the total capital investment in a project.

74.6(5) *Review process.*

a. Applications will be reviewed by staff for completeness and eligibility. If the applicant had previously consulted with the coordinator in completion of the application, the department may refer the application to the coordinator for further feasibility studies if deemed necessary. Applications will be reviewed as described in 261—Chapter 175.

b. The department may consult with other state agencies regarding any possible future environmental, health, or safety issues linked to technology related to the biotechnology industry.

c. The department reserves the right to informally consult with external resources to assist in the evaluation of projects or to contract with outside consultants, in an amount not to exceed $20,000 per project, for the same purpose.

74.6(6) *Evaluation criteria.* The department shall evaluate applications based on the following criteria:

a. Feasibility. The company must submit a feasible business plan which demonstrates managerial and technical expertise.

b. Priority components. The department will review the degree to which the proposed project meets one of the component elements which include:

(1) Innovative agricultural products and processes.

(2) Innovative and new renewable fuels.

(3) Agricultural biotechnology, agricultural biomass and alternative energy.

(4) Organic products and emerging markets.

c. Utilization. The department will review the degree to which the facility will add value to and increase the utilization of agricultural commodities in this state.

d. Producer ownership. The level of producer ownership will be given additional consideration.

e. Rural region. The department will review the extent to which the existing or proposed facility is located in a rural region of the state.

f. Local match. A business applying for financial assistance under the value-added agriculture component is eligible for financial assistance regardless of whether the business has received matching funds from a city or county.

g. Need. The department will review the level of need of the region where the existing facility is located or the proposed facility is to be located.

h. Coproducts. The department will review the degree to which the facility produces a coproduct which is marketed in the same locality as the facility.

i. In-state suppliers. The department will review the extent to which the facility utilizes in-state suppliers of inputs and feedstocks for processing and manufacturing.

j. Sales. The department will review the extent to which the facility sells its products outside the state.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—74.7(83GA,SF344) Disaster recovery component.

74.7(1) *Eligibility.* In order to qualify for financial assistance under the disaster recovery component of the program, a business shall meet all of the following conditions:

a. The business is located in an area declared a disaster area by a federal official.

b. The business has sustained substantial physical damage and has closed as the result of a natural disaster. For purposes of this rule, "sustained substantial physical damage" means damage of any origin sustained by a structure or the machinery and equipment contained within whereby the cost of restoring the structure to its before-damaged condition or replacing the machinery and equipment would exceed 50 percent of the market value of the structure or machinery and equipment before the damage occurred. If the business is located in a multitenant building, the market value of the structure before the damage

occurred may be prorated based on the percentage of space within the building which the business occupies.

c. The business must commit to bringing its employment level up, within six months of the award date, to at least 90 percent of its base employment prior to the closure of the business due to the natural disaster in a presidentially declared disaster area. The business shall submit payroll records to establish the business's employment base prior to the date of the presidential disaster declaration.

d. The business must commit to paying wages, within six months of the award date, that are no less than the wages paid prior to the closure of the business due to the natural disaster in a presidentially declared disaster area. The business shall submit payroll records to establish the wages that were paid prior to the date of the presidential disaster declaration.

e. The business must apply for assistance within 12 months of the date of the declaration of disaster by a federal official.

74.7(2) *Local match not required.* A business applying for financial assistance under the disaster recovery component is eligible for financial assistance regardless of whether the business has received matching funds from a city or county.

These rules are intended to implement 2009 Iowa Acts, Senate File 344, section 3.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

[Filed Emergency ARC 7970B, IAB 7/15/09, effective 7/1/09]

CHAPTER 75
OPPORTUNITIES AND THREATS PROGRAM

261—75.1(83GA,SF344) Purpose. The purpose of the opportunities and threats program is to fund projects that present a unique opportunity for economic development in the state of Iowa or projects that address a situation constituting a threat to continued economic prosperity in Iowa.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—75.2(83GA,SF344) Administrative procedures. The opportunities and threats program is subject to the requirements of the department's rules located in 261—Part VII, additional application requirements and procedures, and 261—Part VIII, legal and compliance. Part VII and Part VIII include standard definitions, standard program requirements, application review and approval procedures, contracting, contract compliance and job counting, and annual reporting requirements.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—75.3(83GA,SF344) Eligible applicants. An eligible applicant may be a business, an individual, a development corporation, a nonprofit organization, a council of government as defined in Iowa Code section 28H.1, or a political subdivision in the state of Iowa.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—75.4(83GA,SF344) Review criteria. When applications are reviewed, the following shall apply:

75.4(1) A project shall not be eligible for financial assistance under another state program. If a project is eligible for assistance under another state program, then the project shall not be eligible for funding under this program.

75.4(2) The project must represent a unique economic development opportunity or involve a unique threat to economic development in the state of Iowa.

75.4(3) An applicant must demonstrate that any financial assistance received under this program leverages additional public or private funds.

75.4(4) An applicant must demonstrate that the project will lead to a positive economic impact for the state of Iowa.

75.4(5) An applicant must demonstrate financial need for assistance. Financial need may be demonstrated with financial statements, narrative statements outlining the financial need, and any other documentation that demonstrates financial need or that is requested by the department.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—75.5(83GA,SF344) Award criteria. An award made under this program shall not exceed 50 percent of the total project cost. The minimum award amount is $25,000. The maximum award amount is $250,000 per fiscal year. The board may award an amount in excess of $250,000 if that award is made over multiple fiscal years and the amount committed for each fiscal year within the multiyear award does not exceed $250,000.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement 2009 Iowa Acts, Senate File 344, section 4.

[Filed Emergency ARC 7970B, IAB 7/15/09, effective 7/1/09]

CHAPTER 76
AGGREGATE TAX CREDIT LIMIT FOR CERTAIN ECONOMIC DEVELOPMENT PROGRAMS

261—76.1(83GA,SF483) Authority. The authority for establishing rules governing the aggregate tax credit limit for certain economic development programs under this chapter is 2009 Iowa Acts, Senate File 483.
[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

261—76.2(83GA,SF483) Purpose. The purpose of the aggregate tax credit limit for certain economic development programs is to limit the amount of tax credits awarded during a fiscal year.
[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

261—76.3(83GA,SF483) Definitions.

"Board" means the Iowa economic development board established in Iowa Code section 15.103.

"Department" means the Iowa department of economic development.
[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

261—76.4(83GA,SF483) Amount of the tax credit cap. The department shall not authorize tax credit awards made under the programs identified in rule 261—76.5(83GA,SF483) in excess of $185 million per fiscal year.
[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

261—76.5(83GA,SF483) Programs subject to the cap.

76.5(1) Awards made under the following economic development programs are subject to the tax credit cap:

a. The assistive device tax credit program.

b. The enterprise zone program (business and housing awards).

c. The film, television, and video project promotion program.

d. The high quality jobs program.

76.5(2) In addition to the programs listed in subrule 76.5(1), the corporate tax research credit under the quality jobs enterprise zone program is also subject to the tax credit cap pursuant to 2009 Iowa Acts, Senate File 483, but this program is no longer utilized by the department. The quality jobs enterprise zone program was replaced with the high quality jobs program.
[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

261—76.6(83GA,SF483) Allocating the tax credit cap. At a scheduled meeting of the board prior to the start of a fiscal year, the board will allocate $185 million among the programs listed in rule 261—76.5(83GA,SF483). The board is not required to allocate a portion of the cap to every program listed. The board may allocate a portion of the cap that is shared by other programs with a common purpose, for example, the business awards made under the enterprise zone program and high quality jobs program. Throughout the fiscal year, the board may review the allocation as necessary, but shall review the allocation at least one time during the fiscal year. Based on its review, the board may make adjustments to the allocation as deemed necessary.
[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

261—76.7(83GA,SF483) Exceeding the cap. When the department recommends one or more awards that, when combined with awards already approved during the fiscal year, exceed the $185 million cap, the board may authorize the department to exceed the cap and approve the award. The aggregate award amount in excess of $185 million will be counted against the tax credit cap for the following fiscal year.
[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

261—76.8(83GA,SF483) Reporting to the department of revenue. The department shall submit an initial report to the department of revenue by August 15, 2009, which shows the initial allocation of the $185 million cap. At the start of each subsequent fiscal year, the department shall prepare a report to

summarize final allocation for the fiscal year that just ended, the total amount of awards made under each program identified in rule 261—76.5(83GA,SF483) during that fiscal year, and the initial allocation for the current fiscal year. The report shall be submitted to the department of revenue on or before August 15 of each year.

[**ARC 7954B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement 2009 Iowa Acts, Senate File 483.

[Filed Emergency ARC 7954B, IAB 7/15/09, effective 7/1/09]

CHAPTER 77
Reserved

CHAPTER 113
COMMUNITY MICROENTERPRISE DEVELOPMENT ORGANIZATION GRANT PROGRAM

261—113.1(15) Purpose. The purpose of the community microenterprise development organization grant program is to support microenterprise development through community microenterprise development organizations. Financial assistance will be in the form of grants to eligible community microenterprise development organizations not to exceed the maximum amount of $80,000 per organization. A match of at least 20 percent is required. The community microenterprise development organization shall use the funds to develop the capacity to provide technical assistance and business training to microentrepreneurs.
[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

261—113.2(15) Definitions.

"Board" means the Iowa economic development board established in Iowa Code section 15.103.

"Community microenterprise development organization" means a community development, economic development, social service, or nonprofit organization that provides training, access to financing, and technical assistance to microenterprises as established in Iowa Code section 15.102(2).

"Department" means the Iowa department of economic development as established in Iowa Code chapter 15.

"Microenterprise" means any business with five or fewer employees that generally lacks collateral and has difficulty securing financing from conventional business lending sources. "Microenterprise" includes start-up, home-based, and self-employed businesses as established in Iowa Code section 15.102(5).

"Organization," for the purpose of this program, means the community microenterprise development organization.
[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

261—113.3(15) Program funding.

113.3(1) The department shall award competitive grants to eligible community microenterprise development organizations. The maximum award shall not exceed $80,000 for any one community microenterprise development organization.

113.3(2) The department shall award grants to at least three community microenterprise development organizations in rural areas of the state that show an economic growth rate lower than the average economic growth rate of the state.

113.3(3) The department shall award grants to at least two community microenterprise development organizations in neighborhoods in urban areas of the state that show high rates of poverty and signs of economic distress.

113.3(4) The form of financial assistance shall be a grant.
[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

261—113.4(15) Matching funds requirement. A grant shall not be awarded unless the community microenterprise development organization can match at least 20 percent of the funds to be awarded. The matching funds may be from private foundations, federal or local government funds, financial institutions, or individuals.
[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

261—113.5(15) Eligible applicants. An eligible applicant must be a community microenterprise development organization serving a rural or an urban community. The organization must provide services to low-income and moderate-income individuals and underserved communities.
[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

261—113.6(15) Application and review process.

113.6(1) To apply for a grant, a community microenterprise development organization shall submit an application for financial assistance, in the form specified by the department, to the Iowa Department of Economic Development, Innovation and Commercialization Division, 200 East Grand Avenue, Des Moines, Iowa 50309. Required forms and instructions are available at this address or on the department's Web site at www.iowalifechanging.com.

113.6(2) The application for financial assistance will be reviewed by department staff. Department staff will make a recommendation to the board regarding an application. The board has final decision-making authority regarding applications for financial assistance. The board may approve, defer or deny an application.

113.6(3) An application for financial assistance shall contain all information required by the department, including but not limited to the following:

a. Geographic service area. A description clearly defining the geographic area the community microenterprise development organization serves. For rural organizations, the description shall include the service area's economic growth rate in relation to the average growth rate of the state. For organizations located in urban neighborhoods of the state, the description shall include the poverty rate and the unemployment rate of the service area.

b. Ability to provide services. To help the department determine the ability of a community microenterprise development organization to provide services to low-income, moderate-income and underserved communities, all of the following shall be described in the application for financial assistance:

(1) The ability to identify potential microentrepreneurs within a community.

(2) The capacity to perform client assessment and screening.

(3) The ability to provide business training and technical assistance.

(4) The capacity to provide assistance in securing financing.

c. Scope of services. A description of the scope of services offered and methods used to ensure the efficient delivery of such services, especially to low-income, moderate-income, and minority individuals.

d. Ability to monitor progress. A description of the organization's ability to monitor the progress of clients and to identify those clients in need of additional technical and financial assistance.

e. Ability to coordinate resources. A description of the organization's ability to build relationships and coordinate resources with other entities supporting microentrepreneurs. These entities may include but are not limited to community colleges, cooperative extension services, small business development centers, business accelerators, targeted small business advocate services, chambers of commerce, community economic development organizations, workforce centers, and community nonprofit service providers that serve low-income and moderate-income individuals.

f. Reporting. A plan to report project outcomes, including: results from client assessments and screening; strategies developed to respond to results; new training and technical assistance capacity developed; the amount of financing secured by targeted populations; the amount of funding secured through for-profit entities; and the benefits to the geographic service area.

g. Financial resources. A statement providing information on the amount and sufficiency of operating funds available.

[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

261—113.7(15) Application selection criteria. Applications for community microenterprise development organization grants shall be selected based upon the following criteria:

113.7(1) *Geographic service area.* The overall geographic diversity of the applicants for grants, including both urban and rural communities.

113.7(2) *Ability to provide services.* The organization's ability to provide services to low-income and moderate-income individuals and underserved communities.

113.7(3) *Services offered.* The scope of services offered and the ability to efficiently deliver such services to low-income, moderate-income, and minority individuals.

113.7(4) *Ability to monitor progress.* The organization's ability to monitor the progress of clients and provide additional technical assistance.

113.7(5) *Ability to coordinate resources.* The organization's ability to build relationships and coordinate resources with other entities supporting microentrepreneurs.

113.7(6) *Reporting.* The organization's plan to report and evaluate outcomes.

113.7(7) *Financial resources.* The amount and sufficiency of operating funds available.

[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

261—113.8(15) Contract and reporting.

113.8(1) *Notice of award.* Successful applicants will be notified in writing of an award of financial assistance, including any conditions and terms of the approval.

113.8(2) *Contract required.* The department shall prepare a contract, which includes but is not limited to a description of the activities to be completed by the community microenterprise development organization(s); conditions of disbursement; required reports; and the repayment requirements imposed in the event the community microenterprise development organization(s) does not fulfill its obligations described in the contract and other specific repayment provisions ("clawback" provisions) to be established on a project-by-project basis.

113.8(3) *Reporting.* An applicant shall submit any information requested by the department in sufficient detail to permit the department to prepare reports deemed necessary by the department, the board, the general assembly or the governor's office.

[**ARC 7764B**, IAB 5/6/09, effective 4/17/09; **ARC 7948B**, IAB 7/15/09, effective 8/19/09]

These rules are intended to implement Iowa Code section 15.240.

[Filed Emergency ARC 7764B, IAB 5/6/09, effective 4/17/09]

[Filed ARC 7948B (Notice ARC 7765B, IAB 5/6/09), IAB 7/15/09, effective 8/19/09]

CHAPTER 165
ALLOCATION OF GROW IOWA VALUES FUND
[Prior to 7/4/07, see 261—Ch 2]

261—165.1(15G,83GA,SF344) Purpose. The purpose of the grow Iowa values fund is to provide financial assistance for business incentives, marketing efforts, and other programs and activities designed to spur the economy and improve the quality of life of Iowans. Moneys in the grow Iowa values fund provide financial assistance for allowable departmental purposes; for state parks pursuant to a plan from the department of natural resources (DNR); for the cultural trust fund; for workforce training and economic development funds of the community colleges; for economic development region initiatives; and for financial assistance to the regents for the University of Northern Iowa, Iowa State University, the University of Iowa, a bioscience organization, and private universities. The rules in this chapter apply to financial assistance awarded from the grow Iowa values fund by the board.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—165.2(15G,83GA,SF344) Definitions. The definitions located in 261—Chapter 173 apply to this chapter.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—165.3(15G,83GA,SF344) Grow Iowa values fund (2009). The grow Iowa values fund (2009) refers to the fund established by Iowa Code chapter 15G as amended by 2009 Iowa Acts, Senate File 344. The fund includes moneys appropriated to the department by the general assembly for the fund, payments of interest, repayments of moneys loaned, and recaptures of grants and loans made pursuant to the fund, and all moneys accruing to the department from the department's administration of preexisting programs. Pursuant to Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2, the fund is under the control of and administered by the department.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—165.4(15G,83GA,SF344) Allocation of annual appropriation for grow Iowa values fund moneys—$50M. Pursuant to Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2, $50 million is appropriated from the grow Iowa values fund to the department each fiscal year for the fiscal period beginning July 1, 2009, and ending June 30, 2015. If the full $50 million is appropriated in a fiscal year, the fund moneys are allocated as described below. If less than $50 million is appropriated in a fiscal year, then the amount available will be reduced on a pro-rata basis. The fund moneys are allocated as follows:

1. $32M—For:

- Departmental administrative costs,
- Awards of financial assistance from the grow Iowa values financial assistance program established in 2009 Iowa Acts, Senate File 344, section 3,
- Marketing,
- A statewide labor shed study,
- Responding to opportunities and threats,
- Technical assistance and information technology,
- Guarantees in existence as of July 1, 2009, under the loan and credit guarantee program,
- Renewable fuels infrastructure program for FY 2010 ($2M), and
- $1M for FY 2010 for research and development related to renewable energy pursuant to 2009 Iowa Acts, House File 817.

2. $3M—For deposit in the innovation and commercialization fund created by 2009 Iowa Acts, Senate File 142.

3. $5M—To the state board of regents for institutions of higher learning under the control of the state board of regents, for specific activities.

4. $1M—For projects in targeted state parks, state banner parks and destination parks.

5. $1M—For the cultural trust fund administered by the department of cultural affairs.

6. $7M—For workforce training and economic development funds of the community colleges.

7. $1M—For economic development region initiatives.

165.4(1) *Board allocation of appropriation to fund for departmental purposes—$32M.* Of the annual appropriation to the fund, the board may allocate $32 million (or a pro-rata amount if the annual appropriation to the fund is less than $50 million) for the following activities:

a. Departmental administrative costs. The board may allocate a portion of the funds to cover administrative costs. No more than $600,000 may be allocated for administrative costs.

b. Awards of financial assistance from the grow Iowa values financial assistance program established in 2009 Iowa Acts, Senate File 344, section 3. The grow Iowa values financial assistance fund consists of six components. The rules for the six components may be found in 261—Chapter 74.

c. Marketing. The board may allocate a portion of the amount available for departmental purposes for marketing proposals pursuant to Iowa Code section 15G.109.

d. Statewide labor shed study. The board may allocate a portion of the funds available to authorize a statewide labor shed study in coordination with the department of workforce development.

e. Responding to opportunities and threats. A portion of the funds may be allocated by the board to respond to opportunities and threats. The rules for this activity are found in 261—Chapter 75.

f. Technical assistance and information technology. The board may allocate a portion of the funds available for procuring technical assistance from either the public or private sector and for information technology purposes.

g. Loan guarantees in existence as of July 1, 2009, under the loan and credit guarantee program.

h. Renewable fuels infrastructure fund established in Iowa Code section 15G.205. For fiscal year 2010, $2 million shall be allocated to the renewable fuels infrastructure fund established in Iowa Code section 15G.205.

i. Renewable energy research and development. For fiscal year 2010, $1 million for research and development related to renewable energy pursuant to 2009 Iowa Acts, House File 817.

165.4(2) *Funding to the state board of regents for institutions of higher learning under the control of the state board of regents for specific activities—$5M.*

a. Use of funds. Five million dollars (or a pro-rata amount if the annual appropriation to the fund is less than $50 million) is available for financial assistance to institutions of higher learning under the control of the state board of regents (Iowa State University (ISU), University of Iowa (U of I), University of Northern Iowa (UNI)). These funds must be used for capacity building infrastructure in areas related to technology commercialization, for marketing and business development efforts in areas related to technology commercialization, entrepreneurship, and business growth, and for infrastructure projects and programs needed to assist in the implementation of activities under Iowa Code chapter 262B.

(1) In allocating moneys to institutions under the control of the state board of regents, the state board of regents shall require the institutions to provide a one-to-one match of additional moneys for the activities funded with moneys provided under this subrule.

(2) The state board of regents may allocate moneys available under this subrule for financial assistance to a single biosciences development organization determined by the department to possess expertise in promoting the area of bioscience entrepreneurship. The organization must be composed of representatives of both the public and the private sector and shall be composed of subunits or subcommittees in the areas of existing identified biosciences platforms, education and workforce development, commercialization, communication, policy and governance, and finance. Such financial assistance shall be used for purposes of activities related to biosciences and bioeconomy development under Iowa Code chapter 262B and to accredited private universities in this state.

b. Annual state board of regents report. Each fiscal year, the state board of regents shall report how the funds were used and allocated among ISU, U of I, UNI, a bioscience organization, and private universities. The report shall be submitted to the department by July 31. In order to determine the impact of the funding applied to accelerate research leading to commercial products/processes and to measure activities that demonstrate successes, the annual report shall include, at a minimum, the following information:

(1) Research and development commercialization agreements executed with Iowa companies (the number, the dollar amount).

(2) Corporate sponsored funding for R&D by Iowa companies (the number, the dollar amount).

(3) University centers and institutes: core laboratory equipment utilized and services provided (hours, samples, dollar amount).

(4) License and option agreements executed with Iowa companies (the number).

(5) New Iowa companies formed and jobs created from the result of licensed technologies (the number).

(6) Revenue to Iowa companies (based on sales) as a result of licensed technologies (the dollar amount).

c. Board action. The board shall review the annual report from the state board of regents and accept, or request additional information regarding, the use of the $5 million allocation from the grow Iowa values fund to the state board of regents. The board will include in its annual grow Iowa values fund report that is required to be submitted by January 31 each year pursuant to Iowa Code section 15.104(9) an evaluation of the annual report received from the state board of regents.

165.4(3) *Funding for projects in targeted state parks, state banner parks and destination parks—$1M.*

a. Use of funds. One million dollars (or a pro-rata amount if the annual appropriation to the fund is less than $50 million) is available for purposes of providing financial assistance for projects in targeted state parks, state banner parks, and destination parks. For purposes of this subrule, "state banner park" means a park with multiple uses and which focuses on the economic development benefits of a community or area of the state.

b. Annual DNR plan. The department of natural resources shall submit a plan to the department for the expenditure of moneys allocated under this subrule. The plan shall focus on improving state parks, state banner parks, and destination parks for economic development purposes.

c. Board action. The board shall approve, deny, modify, or defer proposed expenditures under the proposed plan for use of the $1 million allocation from the grow Iowa values fund for state parks. Upon approval of the plan, a contract shall be executed between the department and the department of natural resources to provide financial assistance to the department of natural resources for support of state parks, state banner parks, and destination parks.

165.4(4) *Funding for the cultural trust fund administered by the department of cultural affairs—$1M.* One million dollars (or a pro-rata amount if the annual appropriation to the fund is less than $50 million) shall be allocated by the department for deposit in the Iowa cultural trust fund created in Iowa Code section 303A.4 and administered by the department of cultural affairs. The department shall transfer the moneys allocated from the grow Iowa values fund for this purpose to the treasurer of state.

165.4(5) *Funding for workforce training and economic development funds of the community colleges—$7M.* Seven million dollars (or a pro-rata amount if the annual appropriation to the fund is less than $50 million) is allocated for deposit into the workforce training and economic development funds of the community colleges created pursuant to Iowa Code section 260C.18A. The department shall transfer the moneys allocated from the grow Iowa values fund to the workforce training and economic development fund.

165.4(6) *Funding for economic development region initiatives—$1M.*

a. Funds available. One million dollars (or a pro-rata amount if the annual appropriation to the fund is less than $50 million) is available for providing assistance to economic development regions. These moneys are allocated as follows:

$350,000—To ISU, for establishment of small business development centers in certain areas of the state.

$50,000—To the department, for assistance to Iowa business resource centers authorized in Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2.

$600,000—To the department, for financial assistance to economic development regions, for the establishment of a regional economic development revenue-sharing pilot project.

b. Allocation of $600,000 for economic development region initiatives. The board shall annually allocate the $600,000 available under this subrule for economic development region initiatives. The $600,000 is available for the following:

(1) Financial assistance to economic development regions. A portion of the $600,000 may be allocated for financial assistance to economic development regions. An economic development region may apply for:

1. Financial assistance for physical infrastructure needs;

2. Financial assistance to assist an existing business threatened with closure due to the potential consolidation of an out-of-state location;

3. Financial assistance to establish and operate an entrepreneurial initiative.

(2) Regional economic development revenue-sharing pilot project. The department may establish and administer a regional economic development revenue-sharing pilot project for one or more regions. The department shall take into consideration the geographical dispersion of the pilot projects. The department shall provide technical assistance to the regions participating in a pilot project.

(3) Designation as an economic enterprise area. An economic development region may apply to the department for approval to be designated as an economic enterprise area. The department shall approve no more than ten regions as economic enterprise areas.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—165.5(15G,83GA,SF344) Board allocation of other moneys in fund.

165.5(1) *Allocation for administrative and operations costs.* In addition to the moneys appropriated to the fund for departmental purposes pursuant to Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2, the board may allocate other moneys credited to the fund pursuant to Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2, for department administrative and operations costs. The board may allocate a portion of the moneys accruing to the fund resulting from preexisting programs that were repealed by 2009 Iowa Acts, Senate File 344: CEBA, EVA, VAAPFAP, PIAP, and LCG. Funds may be allocated by the board in an amount necessary to fund administrative and operations costs of the department. This allocation is in addition to any allocations the board makes pursuant to subrule 165.4(1).

165.5(2) *Allocation of other moneys for fund purposes.* The board may allocate for other allowable fund purposes a portion of the moneys accruing to the fund resulting from preexisting programs that were repealed by 2009 Iowa Acts, Senate File 344: CEBA, EVA, VAAPFAP, PIAP, and LCG. This allocation is in addition to any allocations the board makes pursuant to subrule 165.4(1).

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—165.6(15G,83GA,SF344) Annual fiscal year allocations by board.

165.6(1) *Annual fiscal year allocations.* At the first scheduled meeting of the board after the start of a fiscal year, the board shall take action on each of the following:

a. Board allocation of appropriation to fund for departmental purposes—$32M. The board shall review the department's recommendation for the annual allocation of the $32 million (or of such lesser amount if the annual appropriation to the fund is less than $50 million) for departmental purposes described in subrule 165.4(1).

b. Board allocation of other moneys in the fund. The board shall review the department's recommendation for the annual allocation of other moneys in the fund as described in rule 261—165.5(15G,83GA,SF344).

c. Board allocation among the six components of the grow Iowa values financial assistance program. The board shall review the department's recommendation for the annual allocation among the six components of the grow Iowa values financial assistance program described in 261—Chapter 74.

165.6(2) *Reallocation during fiscal year.* The board may adjust each of the allocations described in subrule 165.6(1) during the fiscal year as necessary.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapter 15G as amended by 2009 Iowa Acts, Senate File 344.

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CHAPTER 173
STANDARD DEFINITIONS

[IAB 7/4/07, 261—Ch 173 renumbered as 261—Ch 199]
[Prior to 7/4/07, see 261—Ch 168, div V]

261—173.1(15,15G,83GA,SF344) Applicability.

173.1(1) *Current programs.* Effective July 1, 2009, this chapter shall apply to the following programs and funding sources:

a. EDSA (economic development set-aside) program (261—Chapter 23).

b. EZ (enterprise zone) program (261—Chapter 59).

c. HQJP (high quality jobs program) (261—Chapter 68).

d. Grow Iowa values fund—IVF(2009).

173.1(2) *Prior programs—transition provision.* The programs listed in paragraphs *"a"* to *"f"* were repealed by 2009 Iowa Acts, Senate File 344, effective July 1, 2009. The rules in effect on June 30, 2009, under this chapter shall apply to the following prior programs until such time as the contracts for these prior programs are closed by the department:

a. VAAPFAP (value-added agricultural products and processes financial assistance program) (261—Chapter 57).

b. CEBA (community economic betterment account) program (261—Chapter 53).

c. EVA (entrepreneurial ventures assistance) program (261—Chapter 60).

d. TSBFAP (targeted small business financial assistance program) (261—Chapter 55).

e. PIAP (physical infrastructure assistance program) (261—Chapter 61).

f. LCG (loan and credit guarantee) program (261—Chapter 69).

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—173.2(15,15G,83GA,SF344) Definitions.

"Agricultural products advisory council" or *"APAC"* means the council which is composed of five members appointed by the secretary of agriculture and five members appointed by the director of the Iowa department of economic development who are experienced in marketing or exporting agricultural commodities or products, financing the export of agricultural commodities or products, or adding value to and the processing of agricultural products as further described in Iowa Code section 15.203 and which reviews value-added agriculture component applications and makes recommendations to the board.

"Award date" means the date the board or the director approved an application for direct financial assistance or tax credit incentives.

"Base employment level" means the number of full-time equivalent positions at a business, as established by the department and a business using the business's payroll records, as of the date a business applies for financial assistance. The number of jobs the business has pledged to create and retain shall be in addition to the base employment level.

"Benefits" means all of the following nonwage compensation provided to an employee: medical and dental insurance plans, pension, retirement, and profit-sharing plans, child care services, life insurance coverage, vision insurance coverage, and disability insurance coverage.

"Board" means the Iowa economic development board established under Iowa Code section 15.103.

"Business" means a sole proprietorship, partnership or corporation organized for profit or not for profit under the laws of the state of Iowa or another state, under federal statutes, or under the laws of another country.

"County wage" means the county wage calculation performed by the department pursuant to 2009 Iowa Acts, Senate File 344, section 3.

"Created job" means a new, permanent, full-time equivalent (FTE) position added to a business's payroll in excess of the base employment level at the time of application for assistance.

"Department" means the Iowa department of economic development created by Iowa Code section 15.105.

"Director" means the director of the Iowa department of economic development.

"Due diligence committee" or *"DDC"* means the due diligence committee composed of members of the board whose duties include, but are not limited to, carrying out any duties assigned by the board in relation to programs administered by the department, reviewing applications for financial assistance, conducting a thorough review of proposed projects and making recommendations to the board regarding funding.

"Employee" means:

1. An individual filling a full-time position that is part of the payroll of the business receiving financial assistance from any of the programs identified in rule 261—173.1(15,15G,83GA,SF344).

2. A business's leased or contract employee, provided all of the following elements are satisfied:

- The business receiving the state financial assistance has a legally binding contract with a third-party provider to provide the leased or contract employee.
- The contract between the third-party provider and the business specifically requires the third-party provider to pay the wages and benefits at the levels required and for the time period required by the department as conditions of the financial assistance award to the business.
- The contract between the third-party provider and the business specifically requires the third-party provider to submit payroll records to the department, in form and content and at the frequency found acceptable to the department, for purposes of verifying that the business's job creation/retention and benefit requirements are being met.
- The contract between the third-party provider and the business specifically authorizes the department, or its authorized representatives, to access records related to the funded project.
- The business receiving the state financial assistance agrees to be contractually liable to the department for the performance or nonperformance of the third-party provider.

"Equity-like investment" means the provision of assistance in such a manner that the potential return on investment to the provider varies according to the profitability of the company assisted. This includes but is not limited to: royalty arrangements; warrant arrangements; or other similar forms of investments.

"Financial assistance" means assistance in the form of grants, loans, forgivable loans, float loans, equity-like investment, and royalty payments and other forms deemed appropriate by the board, consistent with Iowa law.

"Fiscal impact ratio" or *"FIR"* means a ratio calculated by estimating the amount of taxes to be received by the state from a business and dividing the estimate by the estimated cost to the state of providing certain financial incentives to the business, reflecting a ten-year period of taxation and incentives and expressed in terms of current dollars. "Fiscal impact ratio" does not include taxes received by political subdivisions.

"Full-time equivalent job" or *"full-time"* means the employment of one person:

1. For 8 hours per day for a 5-day, 40-hour workweek for 52 weeks per year, including paid holidays, vacations and other paid leave; or

2. The number of hours or days per week, including paid holidays, vacations and other paid leave, currently established by schedule, custom, or otherwise, as constituting a week of full-time work for the kind of service an individual performs for an employing unit.

"Grant" means an award of assistance with the expectation that, with the fulfillment of the conditions, terms and obligations of the contract with the department for the project, repayment of funds is not required.

"ICF" means the innovation and commercialization fund established by 2009 Iowa Acts, Senate File 142.

"IVF(2009)" means the grow Iowa values fund established by Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2.

"Loan" means an award of assistance with the requirement that the award be repaid with term, interest rate, and other conditions specified as part of the award. A "deferred loan" is one for which the payment for principal, interest, or both, is not required for some specified period. A "forgivable loan" is one for which repayment is eliminated in part or entirely if the borrower satisfies specified conditions. A "float loan" means a short-term loan (maximum of 30 months) from obligated but unexpended IVF(2009) funds.

"Loan and credit guarantee committee" means the loan and credit guarantee committee composed of members of the board and whose duties include, but are not limited to, carrying out any duties assigned by the board in relation to the loan and credit guarantee program administered by the department, reviewing loan and credit guarantee applications and making recommendations to the board regarding funding.

"Loan guarantee" means a guarantee of all or part of a loan made by a commercial lender. Payment of all or a portion of the loan guarantee would occur if the business defaults on its repayment of the loan, provided the lender has exhausted standard legal remedies in an attempt to secure repayment from the borrower.

"Maintenance period" means the period of time between the project completion date and the maintenance period completion date.

"Maintenance period completion date" means the date on which the maintenance period ends. It is the specific date established by the department past the project completion date through which the recipient shall maintain the project, the created jobs, and the retained jobs.

"Project completion," for the EZ and HQJP tax credit programs, for purposes of reporting to the Iowa department of revenue that a project has been completed, means:

1. For new manufacturing facilities, the first date upon which the average annualized production of finished product for the preceding 90-day period at the manufacturing facility is at least 50 percent of the initial design capacity of the facility.
2. For all other projects, the date of completion of all improvements necessary for the start-up, location, expansion or modernization of a business.

"Project completion date" means the specific date established by the department by which a recipient of financial assistance shall have completed all pledged project activities, met its job creation and job retention obligations, and otherwise satisfied the terms and obligations of the contract with the department for a project. (See rule 261—187.3(15) for a listing of the duration of the project completion period and maintenance period for IDED's job creation and tax credit programs.)

"Project completion period" means the period of time between the date financial assistance is awarded (the "award date") and the project completion date.

"Project initiation" means, for all programs and funding sources except EDSA, any one of the following:

1. The start of construction of new or expanded buildings;
2. The start of rehabilitation of existing buildings;
3. The purchase or leasing of existing buildings; or
4. The installation of new machinery and equipment or new computers to be used in the operation of the business's project.

The purchase of land or signing an option to purchase land or earth moving or other site development activities not involving actual building construction, expansion or rehabilitation shall not constitute project initiation. The costs of any land purchase and site development work incurred prior to the award are not eligible qualifying investment expenses.

"Qualifying wage threshold" means the county wage or the regional wage, as calculated by the department, whichever is lower.

"Regional wage" means the regional wage calculation performed by the department pursuant to 2009 Iowa Acts, Senate File 344, section 3.

"Retained job" means a full-time equivalent permanent position in existence at the time an employer applies for financial assistance which remains continuously filled or authorized to be filled as soon as possible and which is at risk of elimination if the project for which the employer is seeking assistance does not proceed.

"Sufficient benefits" means that the employer applying for financial assistance offers to each full-time equivalent permanent position a benefits package that meets one of the following:

1. The employer pays 80 percent of the premium costs for a standard medical and dental plan for single employee coverage with a $750 maximum deductible; or
2. The employer pays 50 percent of the premium costs for a standard medical and dental plan for employee family coverage with a $1,500 maximum deductible; or

3. The employer provides medical coverage and pays the monetary equivalent of paragraph "1" or "2" above in supplemental employee benefits. Benefits counted toward monetary equivalent could include medical coverage, dental coverage, vision insurance, life insurance, pension, retirement (401k), profit sharing, disability insurance, child care services, and other nonwage compensation approved by the board.

"Sufficient benefits credit" means a benefits credit for which a business qualifies if the business provides sufficient benefits to each employee holding a created or retained job. This credit can be applied against the 130 percent qualifying wage requirement. The credit shall be calculated and applied as follows:

1. By multiplying the qualifying wage threshold of the county in which the business is located by one and three-tenths.
2. By multiplying the result of paragraph "1" by one-tenth.
3. The amount of the result of paragraph "2" shall be credited against the amount of the 130 percent qualifying wage threshold requirement that the business is required to meet.
4. The credit shall not be applied against the 100 percent qualifying wage threshold requirement.

"Technology commercialization committee" means the committee established by the board pursuant to Iowa Code section 15.116 to evaluate and approve funding for projects and programs referred to in Iowa Code section 15G.111 as amended by 2009 Iowa Acts, Senate File 344, section 2.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapters 15, 15G as amended by 2009 Iowa Acts, Senate File 344, and 17A.

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CHAPTER 174
WAGE, BENEFIT, AND INVESTMENT REQUIREMENTS
[Prior to 7/4/07, see 261—Ch 168, div IV]

261—174.1(15,15G,83GA,SF344) Applicability. This chapter is applicable to the programs identified in 261—173.1(15,15G,83GA,SF344).
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.2(15,15G,83GA,SF344) Annual qualifying wage threshold calculations.

174.2(1) The department will update the county and regional qualifying wage thresholds annually each fiscal year, and these thresholds will become effective on July 1 of each fiscal year.

174.2(2) Effective date of county wage and regional wage qualifying thresholds. Businesses that submit a project review form to the department will be subject to county and regional qualifying wage thresholds in effect on the date the department receives the project review form provided that the business's application is received and approved within six months of the date the project review form was received by the department. If more than six months have elapsed, the business will be subject to the wage thresholds in effect on the date the department receives the business's completed application.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.3(15,15G,83GA,SF344) Qualifying wage threshold requirements—prior to July 1, 2009. 2009 Iowa Acts, Senate File 344, became effective on July 1, 2009. 2009 Iowa Acts, Senate File 344, repealed a number of programs administered by the department, established IVF(2009), and transferred moneys from prior programs to the IVF(2009). This resulted in a simplification of state financial assistance programs. The following subrules regarding qualifying wage thresholds apply to awards made on or before June 30, 2009. This rule shall apply to the prior programs and funding sources until such time as the contracts for these prior programs are closed by the department.

174.3(1) *Qualifying wage threshold requirement—projects receiving IVF(FES) assistance.* Awards funded during the time period beginning July 1, 2003, but before June 16, 2004, from IVF(FES) shall meet the wage requirements in effect at that time as reflected in the contract between the department and the business. Awards funded after June 16, 2004, using IVF(FES) moneys shall meet the qualifying wage thresholds for the programs through which funding is sought.

174.3(2) *Qualifying wage threshold requirement—projects receiving IVF (2005) assistance.* In order to receive financial assistance from the IVF (2005), applicants shall demonstrate that the annual wage, including benefits, of project jobs is at least 130 percent of the average county wage. If an applicant is applying for IVF (2005) moneys, the department will first review the application to ensure that the IVF (2005) wage requirement is met. The department will then review the application for compliance with the requirements of the department program from which financial assistance is to be provided.

174.3(3) *Qualifying wage threshold requirement—projects funded by program funds ("old money").* Prior to July 1, 2003, direct financial assistance programs administered by the department were funded through state appropriations. After the creation of IVF(FES) and IVF (2005), these programs no longer received separate state appropriations. These programs were funded with IVF(FES) and IVF (2005) moneys. Moneys remaining, recaptured or repaid to these program funds remain available for awarding to projects. The department will review an application for compliance with the requirements of the department program from which financial assistance is to be provided.

174.3(4) *Qualifying wage threshold requirement—projects receiving EDSA funds.* EDSA is the job creation component of the federal CDBG program. The department will review an application for compliance with the federal CDBG EDSA requirements.

174.3(5) *Qualifying wage thresholds, by funding source and by program.*

a. IVF (2005). Projects that are funded with IVF (2005) moneys through the following programs shall meet the qualifying wage threshold listed below:

Funding Source: IVF (2005)		Qualifying Wage Threshold Requirement	Can benefits value be added to the hourly wage to meet the qualifying wage threshold?
CEBA:	Small business gap financing component	130% of average county wage	Yes
	New business opportunities and new product development components	130% of average county wage	Yes
	Venture project component	130% of average county wage	Yes
	Modernization project component	130% of average county wage	Yes
VAAPFAP		130% of average county wage	Yes
PIAP		130% of average county wage, unless funded through special allocation of PIAP funds, up to $5 million, established in subrule 61.5(12)	Yes
EVA		130% of average county wage	Yes

b. IVF(FES) and program funds. Projects that are funded with IVF(FES) through the following programs or directly from available program fund moneys shall meet the qualifying wage thresholds listed below:

Funding Source: IVF(FES) or Program Funds		Qualifying Wage Threshold Requirement	Can benefits value be added to the hourly wage to meet the qualifying wage threshold?
CEBA:	Small business gap financing component	100% of average county wage or average regional wage, whichever is lower 130% for awards over $500,000	No
	New business opportunities and new product development components	100% of average county wage or average regional wage, whichever is lower 130% for awards over $500,000	No
	Venture project component	100% of average county wage or average regional wage, whichever is lower	No
	Modernization project component	100% of average county wage or average regional wage, whichever is lower 130% for awards over $500,000	No
VAAPFAP		No statutory requirement	Not applicable
PIAP		No statutory requirement	Not applicable
EVA		No statutory requirement	Not applicable

c. *EDSA.* Projects that are funded with EDSA moneys shall meet the following wage threshold:

Program Source: CDBG	Wage Threshold Requirement	Can benefits value be added to the hourly wage to meet the wage threshold?
EDSA	100% of average county wage or average regional wage, whichever is lower	No

d. *EZ and HQJC.* Tax credit program projects shall meet the following wage thresholds:

Tax Credit Program	Wage Threshold Requirement	Can benefits value be added to the hourly wage to meet the wage threshold?
EZ	90% of average county wage or average regional wage, whichever is lower	No
HQJC	130% of average county wage More benefits are available if the wage rate is 160% or higher	Yes

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.4(15) IVF (2005) wage waivers; HQJC eligibility requirement waivers. Rescinded IAB 11/5/08, effective 10/16/08.

261—174.5(15G,83GA,SF344) Qualifying wage threshold requirements—on or after July 1, 2009.

174.5(1) Projects that are funded through one of the IVF(2009) financial assistance program components shall meet the following qualifying wage thresholds:

Funding Source: IVF(2009) Grow Iowa Values Financial Assistance Program		Qualifying Wage Threshold Requirement	Credit for sufficient benefits?
Program Component:	130% wage component	130% of county wage or regional wage, whichever is lower	Yes
	100% wage component	100% of county wage or regional wage, whichever is lower	No
	Entrepreneurial component	No qualifying wage threshold	Not applicable
	Infrastructure component	No qualifying wage threshold	Not applicable
	Value-added agriculture component	No qualifying wage threshold	Not applicable
	Disaster recovery component	No qualifying wage threshold	Not applicable

174.5(2) HQJP and EZ. Projects funded through the HQJP or EZ tax credit program shall meet the following qualifying wage thresholds:

Tax Credit Programs	Qualifying Wage Threshold Requirement	Credit for sufficient benefits?
HQJP	130% of county wage or regional wage, whichever is lower	Yes
EZ	90% of county wage or regional wage, whichever is lower	No

174.5(3) EDSA. Projects that are funded with EDSA moneys shall meet the following wage threshold:

Program Source: CDBG	Qualifying Wage Threshold Requirement	Credit for sufficient benefits?
EDSA	90% of county wage or regional wage, whichever is lower	No

174.5(4) Higher wage threshold applies if multiple programs are used in a project. Notwithstanding the qualifying wage threshold requirements for each program, if a business is a recipient of financial assistance from more than one program administered by the department and the qualifying wage thresholds are not the same, the business shall be required to pay the higher qualifying wage for the project.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.6(15E,15G,83GA,SF344) Wage waiver requests—130 percent wage component and HQJP.

174.6(1) *Waiver of qualifying wage threshold—130 percent wage component.* An applicant may apply to the board for a waiver of the qualifying wage threshold requirements of the 130 percent wage component of the grow Iowa values financial assistance program. The procedures to follow to request such a waiver are described in rule 261—175.5(15,15G,83GA,SF344).

174.6(2) *Waiver of HQJP qualifying wage threshold.* A community may apply to the board for a project-specific waiver from the qualifying wage threshold requirement in order to seek tax incentives for an eligible business. The procedures to follow to request such a waiver are described in rule 261—175.5(15,15G,83GA,SF344).
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.7(15,15G,83GA,SF344) Job obligations. Jobs that will be created or retained as a result of a project's receiving state or federal financial assistance or tax credit benefits from the department shall meet the qualifying wage threshold requirements. Jobs that do not meet the qualifying wage threshold requirements will not be counted toward a business's job creation or job retention obligations outlined in the contract between the department and the business. A business's job obligations shall include the business's base employment level and the number of new jobs required to be created above the base employment level.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.8(15,15G,83GA,SF344) Benefit requirements—prior to July 1, 2009. This rule regarding benefit requirements applies to awards made on or before June 30, 2009. This rule shall apply to the prior programs and funding sources until such time as the contracts for these prior programs are closed by the department.

Program	Benefit Requirement	Deductible Requirements	Is a monetary equivalent to benefits allowed?	Benefits Counted Toward Monetary Equivalent
EZ	80% medical and dental coverage, single coverage only OR the monetary equivalent	$750 maximum for single coverage/ $1500 maximum for family coverage	Yes	-Medical coverage (family portion) -Dental coverage (family portion) -Pension/401(k) (company's average contribution) -Profit-sharing plan -Life insurance -Short-/long-term disability insurance -Vision insurance -Child care
HQJC	No benefit requirement (If, however, the company does not provide 80% medical and dental coverage for a single employee, the award will be reduced by 10%.)	$750 maximum for single coverage/ $1500 maximum for family coverage	No (Providing 80% medical and dental coverage for a single employee is one of eight qualifying criteria the company may use to qualify for the program. Monetary equivalent of other benefits is not considered.)	Not applicable

Program	Benefit Requirement	Deductible Requirements	Is a monetary equivalent to benefits allowed?	Benefits Counted Toward Monetary Equivalent
EDSA	80% medical and dental for single employees OR 50% medical and dental for family coverage OR the monetary equivalent	$750 maximum for single coverage/ $1500 maximum for family coverage	Yes	-Medical coverage (family portion) -Dental coverage (family portion) -Pension/401(k) (company's average contribution) -Profit-sharing plan -Life insurance -Short-/long-term disability insurance -Vision insurance -Child care -Other documented benefits offered to all employees (i.e., uniforms, tuition reimbursement, etc.)
CEBA	80% medical and dental for single employees OR 50% medical and dental for family coverage OR the monetary equivalent	$750 maximum for single coverage/ $1500 maximum for family coverage	Yes	-Medical coverage (family portion) -Dental coverage (family portion) -Pension/401(k) (company's average contribution) -Profit-sharing plan -Life insurance -Short-/long-term disability insurance -Vision insurance -Child care -Other documented benefits offered to all employees (i.e., uniforms, tuition reimbursement, etc.)
VAAPFAP	Not applicable	Not applicable	Not applicable	Not applicable
PIAP	Not applicable	Not applicable	Not applicable	Not applicable
EVA	Not applicable	Not applicable	Not applicable	Not applicable
TSBFAP	Not applicable	Not applicable	Not applicable	Not applicable

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.9(15,15G,83GA,SF344) Sufficient benefits requirement—on or after July 1, 2009. To be eligible to receive state financial assistance or tax credit benefits, applicants shall offer sufficient benefits to each FTE permanent position. "Sufficient benefits" and "sufficient benefits credit" are defined in rule 261—173.2(15,15G,83GA,SF344). An employer may select one of the following options to meet the sufficient benefits requirement:

Option 1 80% Single Coverage	Option 2 50% Family Coverage	Option 3 Monetary Equivalent	
Pay 80% of premium costs for a standard medical and dental plan, single coverage. $750 maximum deductible	Pay 50% of premium costs for a standard medical and dental plan, family coverage. $1,500 maximum deductible	Provide medical and pay the monetary equivalent of Option 1 or Option 2 in supplemental employee benefits.	Benefits Counted Toward Monetary Equivalent ● Medical coverage ● Dental coverage ● Vision insurance ● Life insurance ● Pension ● 401(k) (company's average contribution) ● Short-/long-term disability insurance ● Child care services ● Other nonwage compensation

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—174.10(15,15G,83GA,SF344) Capital investment, qualifying investment for tax credit programs, and investment qualifying for tax credits.

174.10(1) *Capital investment.* The department reports on the amount of capital investment involved with funded projects. This rule lists the categories of expenditures that are included when the department determines the amount of capital investment associated with a project.

174.10(2) *Qualifying investment for tax credit programs.* For the tax credit programs (EZ and HQJP), there are statutorily required minimum investment thresholds that must be met for the project to be considered to receive an award. Not all expenditures count toward meeting the investment threshold. This rule identifies the categories of expenditures that can be included when the amount of investment is calculated for purposes of meeting program eligibility threshold requirements.

174.10(3) *Investment qualifying for tax credits.* Not all of the expenditures categories used to calculate the investment amount needed to meet program threshold requirements qualify for purposes of claiming the tax credits. The following table identifies the expenditures that do not qualify for tax credits.

	Capital Investment[1]	Qualifying Investment[2]	Investment Qualifying for Tax Credits[3]
Land acquisition	Yes	Yes	Yes
Site preparation	Yes	Yes	Yes
Building acquisition	Yes	Yes	Yes
Building construction	Yes	Yes	Yes
Building remodeling	Yes	Yes	Yes
Mfg. machinery & equip.	Yes	Yes	Yes
Other machinery & equip.	Yes	No	No
Racking, shelving, etc.	Yes	No	No
Computer hardware	Yes	Yes	Yes
Computer software	No	No	No
Furniture & fixtures	Yes	Yes	No
Working capital	No	No	No
Research & development	No	No	No
Job training	No	No	No
Capital or synthetic lease	No	Yes	Yes
Rail improvements[4]	Yes	Yes	Yes
Public infrastructure[5]	Yes	Yes	Yes

[1] "Capital investment" is used to calculate project investment on depreciable assets.

[2] "Qualifying investment" is used to determine eligibility for EZ and HQJC programs.

[3] "Investment qualifying for tax credits" is used to calculate the maximum available tax credit award for a project.

[4] "Rail improvements" includes hard construction costs for rail improvements. (These costs are included as part of construction or site preparation costs.)

[5] "Public infrastructure" includes any publicly owned utility service such as water, sewer, storm sewer or roadway construction and improvements. (These costs are included as part of construction costs.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapters 15, 15E and 15G as amended by 2009 Iowa Acts, Senate File 344.

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CHAPTER 175
APPLICATION REVIEW AND APPROVAL PROCEDURES

261—175.1(15,83GA,SF344) Applicability. This chapter shall apply to the programs listed in rule 261—173.1(15,15G,83GA,SF344) and to other state and federal programs identified in this chapter. This chapter describes the application review and approval procedures and the role of the advisory groups or board committees and identifies the final decision maker for each program.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—175.2(15,83GA,SF344) Application procedures for programs administered by the department.

175.2(1) *IVF(2009).* Effective July 1, 2009, pursuant to 2009 Iowa Acts, Senate File 344, the grow Iowa values fund was updated, streamlined and simplified, preexisting state financial assistance programs were repealed and previous funding for these programs was transferred to IVF(2009). The fund is administered by the department, and the board has final decision-making authority for IVF(2009) financial assistance awards and other activities.

175.2(2) *IVF (2005).* Rescinded IAB 7/15/09, effective 7/1/09.

175.2(3) *Projects funded by program funds ("old money").* Rescinded IAB 7/15/09, effective 7/1/09.

175.2(4) *Tax credit programs.* The department administers tax credit programs that provide tax incentives for approved projects. The department will review an application to ensure that the project meets the requirements for the tax credit programs through which an applicant is applying.

175.2(5) *Federal programs.* The department administers federal programs including, but not limited to, the HOME program and the CDBG program. EDSA is the job creation component of the CDBG program. The department will review an application to ensure that the project meets the requirements for the programs through which an applicant is applying.

175.2(6) *Other state programs.* In addition to the programs described herein, the department administers other state programs. The department will review an application to ensure that the project meets the requirements for the tax credit programs through which an applicant is applying.

175.2(7) *Application required.* A business or community seeking financial assistance or tax credit benefits from a department program shall submit an application to the department. The applicant shall comply with the department's application procedures, processes, rules, and, as applicable, the wage and benefit requirements for that program and its funding source. Application forms and directions for completing the forms are available online at the department's Web site at www.iowalifechanging.com or at the department's offices located at 200 East Grand Avenue, Des Moines, Iowa 50309.
[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—175.3(15,83GA,SF344) Standard program requirements. In addition to the eligibility requirements of the individual programs applicable to the financial assistance sought, an applicant shall be subject to all of the following requirements:

175.3(1) *Environmental and worker safety.* The applicant shall submit to the department with its application for financial assistance a report describing all violations of environmental law or worker safety law within the last five years. If, upon review of the application, the board finds that a business has a record of violations of the law, statutes, rules, or regulations that tends to show a consistent pattern, the board shall not make an award of financial assistance to the business unless the board finds either that the violations did not seriously affect public health, public safety, or the environment or, if such violations did seriously affect public health, public safety, or the environment, that mitigating circumstances were present.

175.3(2) *Sustained operations.* The applicant shall not have closed or substantially reduced operations in one area of this state and relocated substantially the same operations in a community in another area of this state. However, this subrule shall not be construed to prohibit a business from expanding its operations in a community if existing operations of a similar nature in this state are not closed or substantially reduced.

175.3(3) *Competition.* The proposed project shall not negatively impact other businesses in competition with the business being considered for assistance. The department shall make a good faith effort to identify existing Iowa businesses within an industry in competition with the business being considered for financial assistance. The department shall make a good faith effort to determine the probability that the proposed financial assistance will displace employees of the existing businesses. In determining the impact on businesses in competition with the business being considered for financial assistance, jobs created or retained as a result of other jobs being displaced elsewhere in the state shall not be considered direct jobs created or retained.

175.3(4) *Legally authorized employment.* The applicant shall only employ individuals legally authorized to work in this state. In addition to any and all other applicable penalties provided by current law, all or a portion of the assistance received by a business which has received financial assistance under the program and is found to knowingly employ individuals not legally authorized to work in this state is subject to recapture by the department.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—175.4(15,83GA,SF344) Review and approval of applications.

175.4(1) *Staff review for eligibility.* Applications received by the department will be reviewed by program staff to ensure that documentation of minimum program eligibility requirements has been submitted by the applicant. Complete applications will be forwarded to the appropriate decision maker for action.

175.4(2) *Additional review factors.* In addition to reviewing an application for eligibility, the department and the board may consider additional factors. Upon review of these additional factors, the board may determine that the applicant is ineligible to receive assistance until such time as the pending resolution of any outstanding issues identified by the board. Additional factors to be considered include:

a. Applicant's past or current performance. If an applicant has received a prior award(s) from the department, the department and board will take into consideration the applicant's past or current performance under the prior award(s).

b. Results of due diligence review. This review will include, but is not limited to, lien searches, reports of violations, lawsuits and other relevant information about the applicant.

c. Report on environmental law compliance. This report is required by rule 261—172.1(15A) and applicable program statutes.

d. Report on violations of law. This report is required by rule 261—172.2(15A) and applicable program statutes.

175.4(3) *Negotiations.* Department staff may negotiate with the applicant concerning dollar amounts, terms, collateral requirements, conditions of award, or any other elements of the project. The board or director may offer an award in a lesser amount or that is structured in a manner different from that requested. Meeting minimum eligibility requirements does not guarantee that assistance will be offered or provided in the manner sought by the applicant.

175.4(4) *Approval procedures.*

a. Approval. Application approval procedures shall comply with statutory requirements for the program or funding source and applicable program rules. The board shall take final action on all applications or activities funded through IVF(2009), HQJP, EZ and other programs as described in the following paragraphs. The director shall take action on all other applications or activities that are not identified as requiring board action. Paragraphs *"b"* to *"e"* describe the review and approval processes, by funding source and program.

Key to tables:

APAC – Agricultural policy advisory committee established in Iowa Code section 15.203 as amended by 2009 Iowa Acts, Senate File 344, section 23.

BRN – Brownfield redevelopment advisory council as established in Iowa Code section 15.294.

CWD – Community and workforce development committee created by the board.

DDC – Due diligence committee established by the board pursuant to Iowa Code section 15.103(6).

LCG – Loan and credit guarantee committee established in Iowa Code section 15.103(6) as amended by 2009 Iowa Acts, Senate File 344, section 18.

TSB – Targeted small business advisory council established in Iowa Code section 15.247(8).

TCC – Technology commercialization committee established in Iowa Code section 15.116 as amended by 2009 Iowa Acts, Senate File 344, section 22.

b. Advisory committee recommendations and final action—state financial assistance programs. The approval process for applications for financial assistance and any other request for funding from the department's direct financial assistance programs is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
Grow Iowa Values Financial Assistance Program:									
130% wage component				•				•	
100% wage component				•				•	
Entrepreneurial component				•				•	
Infrastructure component				•				•	
Value-added agriculture component	•							•	
Disaster recovery component				•				•	
Loan and Credit Guarantee Program					•				
Other Iowa Values Fund (2009) activities:									
Marketing								•	
Labor shed study								•	
Technical assistance and information technology								•	
Opportunities and threats								•	
All other IVF assistance								•	
Innovation and Commercialization Fund:									
Demonstration Fund							•	•	
Information Technology Training Program							•	•	
Targeted Industries Internship Program							•	•	
Community College Equipment and Training Fund							•	•	

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
Targeted Industries Networking Fund							●	●	
Targeted Industries Student Competition Fund							●	●	
Targeted Industries Career Awareness Fund							●	●	
Lean Manufacturing Institute Program							●	●	
Supplier Capacity and Product Database Program							●	●	
Management Talent Recruitment Program							●	●	

c. Advisory committee recommendations and final action—tax credit programs. The approval process for applications for financial assistance and any other request for funding from the department's tax credit programs is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
High Quality Jobs				●				●	
Enterprise Zone									
Business				●				●	
Housing									●
Film, Television, and Video Project Promotion									●
Assistive Device Tax Credits									●

d. Advisory committee recommendations and final action—federal programs. The approval process for applications for financial assistance and any other request for funding from the department's federal programs is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
HOME									●
CDBG									
EDSA				●				●	
All other CDBG assistance									●
Neighborhood Stabilization Program									●

e. Advisory committee recommendations and final action—other department-administered programs. The approval process for applications for financial assistance and any other request for funding from other department-administered programs is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TCC	TSB	Board	Director
Brownfield Redevelopment Program		•							•
Targeted Small Business Financial Assistance Program							•		•
Export Trade Assistance Program									•
Accelerated Career Education Program			•					•	
Targeted Jobs Withholding Tax Credit Program									•

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—175.5(15,15G,83GA,SF344) Procedures for waiver of wage and other program requirements.

175.5(1) *General information.* Within the parameters described in this rule, the board may, for good cause shown, waive qualifying wage threshold requirements. 2009 Iowa Acts, Senate File 344, section 3, permits applicants to apply to the board for a waiver of the qualifying wage threshold for the 130 percent wage component of the grow Iowa values financial assistance program. Iowa Code section 15.335A(3) as amended by 2009 Iowa Acts, Senate File 344, section 16, allows a community to apply to the board for a project-specific waiver from the qualifying wage threshold requirement provided in the HQJP in order to seek tax incentives for an eligible business.

175.5(2) *Definition of "good cause."* For purposes of this rule, "good cause" can include, but is not limited to, documentation of any of the following:

a. Economic distress. An applicant can establish good cause by demonstrating that the proposed project is located or plans to locate in an area that has experienced economic distress. Data that can be used to establish economic distress may be based on a combination of factors including, but not limited to:

(1) A county family poverty rate significantly higher than the state average.

(2) A county unemployment rate significantly higher than the state average.

(3) A unique opportunity to use existing unutilized facilities in the community.

(4) A significant downsizing or closure by one of the community's major employers.

(5) An immediate threat posed to the community's workforce due to the downsizing or closure of a business.

b. Targeted industry project. An applicant can establish good cause by demonstrating that the proposed project meets all of the following criteria:

(1) The business is in one of the state's targeted industry clusters: life sciences, information solutions, and advanced manufacturing.

(2) All jobs created as a result of the project have a qualifying wage threshold equal to or greater than 100 percent of the county wage.

(3) The business is headquartered in Iowa or, as a result of the proposed project, will be headquartered in Iowa. In lieu of the business's being headquartered in Iowa, the proposed project has unique aspects which will assist the department in meeting one or more of its strategic objectives.

175.5(3) *Request to waive HQJP qualifying wage threshold requirement.*

a. Iowa Code section 15.335A(3) as amended by 2009 Iowa Acts, Senate File 344, section 16, authorizes a community to request a project-specific waiver from the qualifying wage threshold requirement in order too seek tax incentives for an eligible business.

b. Upon a showing of good cause as defined in subrule 175.5(2), the board may grant a project-specific waiver from the county or regional wage calculations for the remainder of a calendar

year based on county wage or regional wage calculations brought forth by the applicant county including, but not limited to, any of the following:

(1) The county wage calculated without wage data from the business in the county employing the greatest number of full-time employees.

(2) The regional wage calculated without wage data from up to two adjacent counties.

(3) The county wage calculated without wage data from the largest city in the county.

(4) A qualifying wage guideline for a specific project based upon unusual economic circumstances present in the city or county.

(5) The annualized, average hourly wage paid by all businesses in the county located outside the largest city of the county.

(6) The annualized, average hourly wage paid by all businesses other than the largest employer in the entire county.

175.5(4) *Request to waive qualifying wage threshold for the 130 percent wage component of the grow Iowa values financial assistance program.*

a. 2009 Iowa Acts, Senate File 344, section 3, allows applicants to apply to the board for a waiver of the 130 percent wage component of the grow Iowa values financial assistance program.

b. Upon a showing of good cause as defined in subrule 175.5(2), the board may grant a project-specific waiver of the qualifying wage threshold for the 130 percent wage component of the grow Iowa values financial assistance program. The board may grant a waiver from the county wage calculations based on county or regional wage calculations brought forth by the applicant including, but not limited to, any of the following:

(1) The county wage calculated without wage data from the business in the county employing the greatest number of full-time employees.

(2) The regional wage calculated without wage data from up to two adjacent counties.

(3) The county wage calculated without wage data from the largest city in the county.

(4) A qualifying wage threshold for a specific project based upon unusual economic circumstances present in the city or county.

(5) The annualized, average hourly wage paid by all businesses in the county located outside the largest city of the county.

(6) The annualized, average hourly wage paid by all businesses other than the largest employer in the entire county.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapters 15, 15E and 15G as amended by 2009 Iowa Acts, Senate File 344.

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PART VIII
LEGAL AND COMPLIANCE

CHAPTER 187
CONTRACTING

[Prior to 7/4/07, see 261—Ch 168, div VI]

261—187.1(15) Applicability. This chapter is applicable to the programs identified in 261—173.1(15).

261—187.2(15) Contract required.

187.2(1) *Notice of award.* Successful applicants will be notified in writing of an award of assistance, including any conditions and terms of the approval.

187.2(2) *Contract required.* The department shall prepare a contract, which includes, but is not limited to, a description of the project to be completed by the business; the jobs to be created or retained; length of the project completion period and maintenance project completion period; the project completion date and maintenance period completion date; conditions to disbursement; a requirement for annual reporting to the department; and the repayment requirements of the business or other penalties imposed on the business in the event the business does not fulfill its obligations described in the contract and other specific repayment provisions ("clawback provisions") to be established on a project-by-project basis.

187.2(3) *Contract-signing deadline.* Successful applicants will be required to execute an agreement with the department within 120 days of the department's or board's approval of an award. Failure to do so may result in action by the entity that approved the award (the department or the board) to rescind the award. The 120-day time limit may be extended by the final decision maker that approved the award (the department or the board) for good cause shown.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—187.3(15) Project completion date and maintenance period completion date.

187.3(1) Projects shall be completed by the project completion date and maintained through the end of the maintenance date. The contract will establish the duration of the project period and maintenance period. Requests to change the project completion date and the maintenance period completion date shall follow the process for an amended award or contract as described in rule 261—187.4(15).

187.3(2) Projects receiving assistance from programs covered by this chapter shall conform to the time periods established by this rule.

187.3(3) By the project completion date, a recipient shall have completed the project as required by the contract. The jobs and project shall be maintained through the end of the maintenance period completion date. The project completion date is calculated by the department from the end of the month during which an award is made. For example, if an award is made on June 13, 2007, the three-year project completion date will be calculated from June 30, 2007. The project completion date for this award would be June 30, 2010. The maintenance period completion date would be June 30, 2012.

187.3(4) The following table describes, by program, the length of the project completion period and the maintenance period:

Program	Project Completion Period	Maintenance Period	Total Contract Length
Grow Iowa Values Financial Assistance Program:			
130% wage component	3 years	2 more years	5 years
100% wage component	3 years	2 more years	5 years
Entrepreneurial component	3 years	2 more years	5 years
Infrastructure component	3 years	2 more years	5 years
Value-added agriculture component	3 years	2 more years	5 years

Program	Project Completion Period	Maintenance Period	Total Contract Length
Disaster recovery component	3 years	2 more years	5 years
High Quality Jobs Program	3 years	2 more years	5 years
Enterprise Zone Program	3 years	2 more years	5 years

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—187.4(15) Contract and award amendment approval procedures.

187.4(1) *General rule.* Generally, the final decision maker that approved the initial award shall approve any amendments or changes to that award.

187.4(2) All award and contract amendments will be reviewed by the applicable committee identified below, and final action will be taken by the board or director, as identified in the following tables.

Key to tables:

APAC – Agricultural policy advisory committee established in Iowa Code section 15.203 as amended by 2009 Iowa Acts, Senate File 344, section 23.

BRN – Brownfield redevelopment advisory council as established in Iowa Code section 15.294.

CWD – Community and workforce development committee created by the board.

DDC – Due diligence committee established by the board pursuant to Iowa Code section 15.103(6).

LCG – Loan and credit guarantee committee established in Iowa Code section 15.103(6) as amended by 2009 Iowa Acts, Senate File 344, section 18.

TSB – Targeted small business advisory council established in Iowa Code section 15.247(8).

TCC – Technology commercialization committee established in Iowa Code section 15.116 as amended by 2009 Iowa Acts, Senate File 344, section 22.

a. Amendments—state financial assistance programs. The approval process to amend an award or a contract for the department's direct financial assistance programs is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
Grow Iowa Values Financial Assistance Program:									
130% wage component				•				•	
100% wage component				•				•	
Entrepreneurial component				•				•	
Infrastructure component				•				•	
Value-added agriculture component	•							•	
Disaster recovery component				•				•	
Loan and credit guarantee program					•			•	
Other Iowa Values Fund (2009) activities:									
Marketing								•	
Labor shed study								•	

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
Technical assistance and information technology								•	
Opportunities and threats								•	
All other IVF assistance								•	
Innovation and Commercialization Fund:									
Demonstration Fund							•	•	
Information Technology Training Program							•	•	
Targeted Industries Internship Program							•	•	
Community College Equipment and Training Fund							•	•	
Targeted Industries Networking Fund							•	•	
Targeted Industries Student Competition Fund							•	•	
Targeted Industries Career Awareness Fund							•	•	
Lean Manufacturing Institute Program							•	•	
Supplier Capacity and Product Database Program							•	•	
Management Talent Recruitment Program							•	•	

b. Amendments—tax credit programs. The approval process to amend an award or a contract for the department's tax credit programs is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
High Quality Jobs				•				•	
Enterprise Zone									
Business				•				•	
Housing									•
Film, Television, and Video Project Promotion									•
Assistive Device Tax Credits									•

c. Amendments—federal programs. The approval process to amend an award or a contract for the department's federal programs is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TCC	TSB	Board	Director
HOME									•
CDBG									
EDSA				•				•	
All other CDBG assistance									•
Neighborhood Stabilization Program									•

d. Amendments—other department-administered programs. The approval process to amend an award or a contract for other programs administered by the department is as follows:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TCC	TSB	Board	Director
Brownfield Redevelopment Program		•							•
Targeted Small Business Financial Assistance Program							•		•
Export Trade Assistance Program									•
Accelerated Career Education Program			•					•	
Targeted Jobs Withholding Tax Credit Program									•

187.4(3) *Amendments and other requests the department is authorized to implement.* The department is authorized by the board to take action on nonsubstantive changes, including but not limited to the following:

a. Recipient name, address and similar changes.

b. Collateral changes that are the same or better security than originally approved by the board or director (e.g., securing a letter of credit to replace a UCC blanket filing) or collateral changes that do not materially and substantially impact the department's security.

c. Line item budget changes that do not reduce overall total project costs.

d. Loan repayment amounts or due dates that do not extend the final due date of a loan.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

261—187.5(15) Default.

187.5(1) *Events of default.* The department may, for cause, determine that a recipient is in default under the terms of the contract. The reasons for which the department may determine that the recipient is in default of the contract include, but are not limited to, any of the following:

a. Any material representation or warranty made by the recipient in connection with the application that was incorrect in any material respect when made.

b. A material change in the business ownership or structure that occurs without prior written disclosure and the permission of the department.

c. A relocation or abandonment of the business or jobs created or retained through the project.

d. Expenditure of funds for purposes not described in the application or authorized in the agreement.

e. Failure of the recipient to make timely payments under the terms of the agreement, note or other obligation.

f. Failure of the recipient to fulfill its job obligations.

g. Failure of the recipient to comply with wage or benefit packages.

h. Failure of the recipient to perform or comply with the terms and conditions of the contract.

i. Failure of the recipient to comply with any applicable state rules or regulations.

j. Failure of the recipient to file the required annual report.

187.5(2) *Layoffs or closures.* If a recipient experiences a layoff within the state or closes any of its facilities within the state prior to receiving the incentives and assistance, the department may reduce or eliminate all or a portion of the incentives and assistance. If a business experiences a layoff within the state or closes any of its facilities within the state after executing a contract to receive the incentives and assistance, the department may consider this an event of default and the business may be subject to repayment of all or a portion of the incentives and assistance that it has received.

187.5(3) *Department actions upon default—direct financial assistance programs.*

a. The department will take prompt, appropriate, and aggressive debt collection action to recover any funds misspent by recipients.

b. If the department determines that the recipient is in default, the department may seek recovery of all program funds plus interest, assess penalties, negotiate alternative repayment schedules, suspend or discontinue collection efforts, and take other appropriate action as the board deems necessary.

c. Determination of appropriate repayment plan. Upon determination that the recipient has not met the contract obligations, the department will notify the recipient of the amount to be repaid to the department. If the enforcement of such penalties would endanger the viability of the recipient, the board may extend the term of the loan to ensure payback, stability, and survival of the recipient. In certain instances, additional flexibility in a repayment plan may be necessary to ensure payback, stability, and survival of the recipient. Flexibility in a repayment plan may include, but is not limited to, deferring principal payments or collecting monthly payments below the amortized amount. In these cases, review and approval by the board, committee or director, as applicable, are necessary before the department may finalize the repayment plan with the recipient.

d. The department shall attempt to collect the amount owed. Negotiated settlements, write-offs or discontinuance of collection efforts is subject to final review and approval by the board, committee or director, as applicable, and described in paragraph *"f."*

e. If the department or board refers defaulted contracts to outside counsel for collection, then the terms of the agreement between the department and the outside counsel regarding scope of counsel's authorization to accept settlements shall apply. No additional approvals by the board, committee or director shall be required.

f. The tables below describe the approval procedures that shall be followed for all negotiated settlements, write-offs or discontinuance of collection efforts for state direct financial assistance programs, federal programs, and other programs administered by the department.

(1) Direct financial assistance programs:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
Grow Iowa Values Financial Assistance Program:									
130% wage component				•				•	
100% wage component				•				•	
Entrepreneurial component				•				•	
Infrastructure component				•				•	

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
Value-added agriculture component	•							•	
Disaster recovery component				•				•	
Loan and Credit Guarantee Program					•			•	
Other Iowa Values Fund (2009) activities:									
Marketing								•	
Labor shed study								•	
Technical assistance and information technology								•	
Opportunities and threats								•	
All other IVF assistance								•	
Innovation and Commercialization Fund:									
Demonstration Fund							•	•	
Information Technology Training Program							•	•	
Targeted Industries Internship Program							•	•	
Community College Equipment and Training Fund							•	•	
Targeted Industries Networking Fund							•	•	
Targeted Industries Student Competition Fund							•	•	
Targeted Industries Career Awareness Fund							•	•	
Lean Manufacturing Institute Program							•	•	
Supplier Capacity and Product Database Program							•	•	
Management Talent Recruitment Program							•	•	

(2) Federal programs:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
HOME									•
CDBG									

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
EDSA				•				•	
All other CDBG assistance									•
Neighborhood Stabilization Program									•

(3) Other programs administered by the department:

PROGRAM	RECOMMENDATION BY:							FINAL DECISION BY:	
	APAC	BRN	CWD	DDC	LCG	TSB	TCC	Board	Director
Brownfield Redevelopment Program		•							•
Targeted Small Business Financial Assistance Program						•			•
Export Trade Assistance Program									•
Accelerated Career Education Program			•					•	
Targeted Jobs Withholding Tax Credit Program									•

187.5(4) *Department actions upon default—tax credit programs.* Collection efforts for tax credit programs are handled by the local community that approved the local tax incentive and the Iowa department of revenue, the state agency responsible for the state tax incentives.

a. Repayment. If an eligible business or eligible housing business has received incentives or assistance under the EZ program or the HQJP and fails to meet and maintain any one of the requirements of the program or applicable rules, the business is subject to repayment of all or a portion of the incentives and assistance that it has received.

b. Calculation of repayment due for a business. If the department, in consultation with the city or county, determines that a business has failed in any year to meet any one of the requirements of the tax credit program, the business is subject to repayment of all or a portion of the amount of incentives received.

(1) Job creation. If a business does not meet its job creation requirement or fails to maintain the required number of jobs, repayment shall be calculated as follows:

1. If the business has met 50 percent or less of the requirement, the business shall pay the same percentage in benefits as the business failed to create in jobs.

2. If the business has met more than 50 percent but not more than 75 percent of the requirement, the business shall pay one-half of the percentage in benefits as the business failed to create in jobs.

3. If the business has met more than 75 percent but not more than 90 percent of the requirement, the business shall pay one-quarter of the percentage in benefits as the business failed to create in jobs.

4. If the business has not met the minimum job creation requirements for the tax credit program, the business shall repay all of the incentives and assistance that it has received.

(2) Wages and benefits. If a business fails to comply with the wage or benefit requirements for the tax credit program, the business shall not receive incentives or assistance for each year during which the business is not in compliance.

(3) Capital investment. If a business does not meet the capital investment requirement, repayment shall be calculated as follows:

1. If the business has met 50 percent or less of the requirement, the business shall pay the same percentage in benefits as the business failed to invest.

2. If the business has met more than 50 percent but not more than 75 percent of the requirement, the business shall pay one-half of the percentage in benefits as the business failed to invest.

3. If the business has met more than 75 percent but not more than 90 percent of the requirement, the business shall pay one-quarter of the percentage in benefits as the business failed to invest.

4. If the business has not met the minimum investment requirement for the tax credit program, the business shall repay all of the incentives and assistance that it has received.

c. Department of revenue; county/city recovery. Once it has been established, through the business's annual certification, monitoring, audit or otherwise, that the business is required to repay all or a portion of the incentives received, the department of revenue and the city or county, as appropriate, shall collect the amount owed. The city or county, as applicable, shall have the authority to take action to recover the value of taxes not collected as a result of the exemption provided by the community to the business. The department of revenue shall have the authority to recover the value of state taxes or incentives provided under Iowa Code section 15E.193A or 15E.196. The value of state incentives provided under Iowa Code section 15E.193A or 15E.196 includes applicable interest and penalties.

d. Layoffs or closures. If an eligible business experiences a layoff within the state or closes any of its facilities within the state prior to receiving the incentives and assistance, the department may reduce or eliminate all or a portion of the incentives and assistance. If a business experiences a layoff within the state or closes any of its facilities within the state after receiving the incentives and assistance, the business shall be subject to repayment of all or a portion of the incentives and assistance that it has received.

e. Extensions. If an eligible business or eligible housing business fails to meet its requirements under the Act, these rules, or the agreement described in rule 261—187.2(15), the department, in consultation with the city or county, may elect to grant the business a one-year extension period to meet the requirements.

[**ARC 7970B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code chapters 15, 15E and 15G as amended by 2009 Iowa Acts, Senate File 344.

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[Filed Emergency ARC 7970B, IAB 7/15/09, effective 7/1/09]

CHAPTER 189
ANNUAL REPORTING

261—189.1(15) Annual reporting by businesses required (for period ending June 30). Recipients shall report annually to the department, in form and content acceptable to the department, about the status of the funded project. The report shall include, but not be limited to, data about base employment, qualifying wages, benefits, project costs, capital investment, and compliance with the contract.

261—189.2(15) January 31 report by IDED to legislature. IDED's legal and compliance group will use the data it collects from businesses to prepare a report on the programs covered in 261—Chapter 173 to be included in IDED's consolidated annual report, which is due to the legislature by January 31 each year pursuant to Iowa Code section 15.104(9) as amended by 2009 Iowa Acts, Senate File 344, section 20.

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[Filed Emergency ARC 7970B, IAB 7/15/09, effective 7/1/09]

CHAPTER 314
RENEWABLE FUEL INFRASTRUCTURE PROGRAM ADMINISTRATION

261—314.1(15G) Allocation of awards by congressional district. The board shall use the boundaries of the state's five congressional districts, and prorate and equally distribute the amount available each fiscal year for each district. The board shall have at its discretion a prorated amount (up to $500,000) to distribute to any congressional district. On April 1 of each year, if funds allocated to a district have not been committed, the unobligated balance shall revert to the reserve fund and be available for other projects approved by the board.

261—314.2(15G) Form of award available; award amount.

314.2(1) *Form of award.* Eligible applicants may apply for financial incentives on a cost-share basis. Funding shall be available in the form of a grant.

314.2(2) *Prospective grants for projects not commenced.* A grant may be awarded for an eligible project not yet commenced.

314.2(3) *Amount of award.*

a. Retail award site.

(1) Three-year cost-share agreement for a retail site. The maximum award amount is 50 percent of the actual cost of making the improvements or $30,000, whichever is less.

(2) Five-year cost-share agreement for a retail site. The maximum award amount is 70 percent of the actual cost of making the improvements or $50,000, whichever is less.

(3) Supplemental financial incentives. A person may be granted supplemental financial incentives as an amendment to the cost-share agreement.

1. Supplemental award for Underwriter Laboratories upgrade. The purpose of an award for Underwriter Laboratories (UL) is to upgrade to UL-certified dispensers, blender pumps and dispensing infrastructure, UL-approved conversion kits and approved and insurable installation project(s). The maximum amount available as a supplemental financial incentive is 75 percent of the actual cost of making the improvements or $30,000, whichever is less. The dispenser can be listed by an independent certified testing laboratory or Underwriter Laboratories (UL) as compatible with ethanol blended gasoline classified as E-9 or higher.

2. Supplemental award for additional tank and associated infrastructure. A person may request a supplemental financial incentive for tank and associated infrastructure, as an amendment to the subsequent cost-share agreement(s). The purpose of an award for an additional tank(s) and associated infrastructure is to accelerate the installation of an additional tank(s) and associated infrastructure at an additional retail motor fuel site after an initial grant award is provided. To be eligible, the initial grant award must be awarded to the person on or after May 12, 2008. The maximum award amount available as a supplemental financial incentive is $6,000 per supplemental site. The person is limited to four supplemental financial incentive awards within the 12-month period following the completion of the initial retail motor fuel site project.

b. Terminal facility award for biodiesel B2 through B98 and B99/B100 for year-round distribution.

(1) Biodiesel fuel B2 through B98.

1. Duration. The duration of the cost-share agreement shall be five years.

2. Maximum award. The maximum award amount is 50 percent of the actual cost of making the improvements or $50,000, whichever is less.

(2) Biodiesel fuel B99/B100 for year-round distribution.

1. Duration. The duration of a cost-share agreement is five years.

2. Maximum award amount. The maximum award amount is 50 percent of the actual cost of making the improvements or $100,000, whichever is less.

3. Application acceptance begins January 1, 2009. Grant applications for B99/B100 projects will be accepted beginning January 1, 2009.

4. Lifetime cap amount. The maximum or lifetime cap for B99/B100 biodiesel terminal grants is $800,000 per person.

c. Tank vehicle.

(1) December 31, 2008, deadline. A tank vehicle application must be postmarked no later than December 31, 2008, to be eligible.

(2) Duration. The duration of the cost-share agreement is three years. The maximum award amount is 50 percent of the actual cost of making the improvements or $30,000, whichever is less.

(3) Limitation on number of grants. A person may receive one grant for one tank vehicle used to store and dispense E-85 gasoline and one grant for one tank vehicle used to store and dispense biodiesel or biodiesel blend. If a person received an award for a tank vehicle(s) prior to May 12, 2008, that person is eligible to apply for an additional tank vehicle.

314.2(4) *Time of payment.* The grant shall be paid only upon timely completion of the project and upon the board's receipt of records satisfying the board of the applicant's qualifying expenditures.

a. The applicant must deliver to the board prior to payment a certificate of completion on the board's form.

b. The certificate of completion must include the IDNR checklist completed and signed by an Iowa-certified installer showing review and approval of the completed project.

c. The certificate of completion must be accompanied by proof of financial responsibility as necessary to meet federal requirements for underground storage tank installation.

314.2(5) *Deadline for completion.* The project must be completed within eight months of the board's approval of the award. An extension may be granted by the board upon application showing demonstrable progress toward completion.

314.2(6) *Multiple awards for multiple fuel types.*

a. At a single fuel site. A person must file a separate application form for an ethanol infrastructure improvement grant and a biodiesel infrastructure improvement grant, respectively, at a single fuel site. The infrastructure board may approve multiple improvements to the same retail motor fuel site for the full amount available for ethanol infrastructure and biodiesel infrastructure. Applications for ethanol and biodiesel infrastructure improvements must be written in separate cost-share agreements.

b. At multiple fuel sites. A person may receive multiple grants as described in paragraph 314.2(6)*"a"* for more than one motor fuel site. When considering multiple grants for multiple fuel sites, the infrastructure board will make awards fairly and properly among applicants and geographic areas.

314.2(7) *Exhaustion of funds.* In the event funding is exhausted at the end of the fiscal year or June 30, 2012, the board shall approve remaining applications based on criteria implemented by the board.

261—314.3(15G) Application process.

314.3(1) *Application procedures.*

a. Applications may be submitted at any time, but will be reviewed on a first-come, first-served basis as established by the date stamp on the filed application.

b. Applications shall be submitted to: Renewable Fuel Infrastructure Board, Iowa Department of Economic Development, 200 East Grand Avenue, Des Moines, Iowa 50309. Application forms and instructions are available at this address.

314.3(2) *Contents of application.*

a. Statutory requirements. An application shall include the information required in Iowa Code Supplement section 15G.203.

b. Other information required by the board:

(1) Assurance that the project will be for the purpose of installing, replacing, or converting equipment for the storage or dispensing of the renewable fuel under consideration.

(2) Assurance that all equipment funded by the grant is designed and will be used exclusively to store or dispense E-85 gasoline, biodiesel or biodiesel blended fuel, respectively, for the period specified in the agreement.

(3) An IDNR checklist indicating the current status of the site.

(4) Assurance of compliance with any and all federal requirements for financial responsibility.

(5) Assurance of compliance with any and all state and federal laws and regulations.

(6) A cost proposal from an Iowa-licensed underground storage tank installer (for underground storage projects) and a qualified aboveground storage tank installer (for aboveground storage projects).

(7) Documentation of initiation of the process of applying to an independent laboratory and the manufacturer's written statement that the dispenser is "not incompatible."

261—314.4(15G) Review process.

314.4(1) The underground storage tank fund board has chosen not to review the applications. The renewable fuel infrastructure board will review an application for final approval or disapproval. The renewable fuel infrastructure board shall determine the amount of financial incentives to be awarded to an applicant.

314.4(2) Completed applications, including supporting documentation of meeting eligibility requirements, will be reviewed on a first-come, first-served basis. If the amount of funding requests exceeds available funds, the board shall evaluate applications based upon criteria that include, but are not limited to, the following:

a. Submittal of a completed application, including supporting documentation.

b. Location factors such as demographics, proximity to major transportation corridors, and proximity to existing renewable fuel retail and storage facilities.

c. Projected annual sales volume.

d. Other sources of funding.

e. Previous grants awarded.

261—314.5(15G) Contract administration.

314.5(1) *Notice of award.* The department shall notify approved applicants in writing of the board's award of grants, including any conditions and terms of the approval.

314.5(2) *Contract required.* The board shall direct the department to prepare a cost-share agreement which shall include terms and conditions of the grant established by the board. The agreement will:

a. Describe the project in sufficient detail to demonstrate the eligibility of the project.

b. State the total cost of the project expressed in a project budget included in sufficient detail to meet the requirements of the infrastructure board.

c. State the project completion deadline.

d. State the project completion requirements which are preconditions for payment of the grant by the board.

e. Recite the penalty for the storage or dispensing of motor fuel other than the type of renewable fuel for which the grant was awarded.

(1) Awards for projects under construction or not yet started. The three- or five-year obligation to continue dispensing renewable fuel begins on the date the project is completed.

(2) Awards for projects already completed. The three- or five-year obligation to continue dispensing renewable fuel begins on the date the department issues the first disbursement of grant funds, not on the date of project completion.

f. Be amended to include a supplemental financial incentive, if a supplemental financial incentive is awarded by the board.

314.5(3) *Repayment penalty for nonexclusive renewable fuel use.* In the absence of a waiver from the board, the department may impose a 25 percent penalty due to a grant recipient's use of infrastructure equipment for which a grant was awarded, for the storage or dispensing, within the time frame stated in the agreement, of motor fuel other than the type of renewable fuel for which the grant was awarded.

314.5(4) *Repayment or board waiver.* A grant recipient may not use the infrastructure to store and dispense motor fuel other than the type approved by the board, unless one of the following applies: (1) the grantee is granted a waiver by the board, or (2) the grantee pays back the moneys awarded including a 25 percent penalty.

314.5(5) *Waiver criteria.* The board may waive repayment of grant funds plus the 25 percent penalty. A grant recipient seeking a waiver during the time period in which a cost-share agreement is in effect

shall submit a written waiver request to the board. The board will consider waiver requests under the following circumstances:

a. Permanent waiver.

(1) Waiver due to demonstration of good cause (no repayment and no 25 percent penalty). A grant recipient may request a permanent waiver during the time period in which a cost-share grant agreement is in effect if the grant recipient can demonstrate good cause for failure to continue using the approved renewable fuel. "Good cause" includes, but is not limited to, events such as the following:

1. Permanent business closure due to bankruptcy.
2. Permanent closure of underground or aboveground storage tanks.

(2) Waiver due to demonstration of financial hardship (repayment on a sliding scale and no 25 percent penalty). A grant recipient may seek a permanent waiver of exclusive use of the approved renewable fuel during the time period in which a cost-share agreement is in effect due to financial hardship. The grant recipient must demonstrate that continuing to dispense the renewable fuel at a project site will cause a financial hardship. A request for waiver due to financial hardship shall include documentation to show a "good faith" effort to market the fuel, specifically the most recent six-month history of gallons of approved renewable fuel sold by month, marketing/advertising efforts, retail price comparison of E-85 to E-10 (or regular gasoline) or of biodiesel to regular diesel. If a waiver is granted, the 25 percent penalty will not be assessed, but the grant funds will be repaid as follows:

1. Three-year cost-share agreement: Months 1 through 11 of the cost-share agreement, 100 percent of grant amount. Months 12 through 36 of cost-share agreement, 4 percent of grant amount for each month remaining on the cost-share agreement.
2. Five-year cost-share agreement: Months 1 through 10 of the cost-share agreement, 100 percent of grant amount. Months 11 through 60 of the cost-share agreement, 2 percent of grant amount for each month remaining on the cost-share agreement.

b. Temporary waiver (temporary suspension of repayment and 25 percent penalty). A grant recipient may request a temporary suspension of the obligation to use only the approved renewable fuel and a temporary waiver of the repayment plus penalty requirement. A request for a temporary waiver, or an extension of a temporary waiver, will only be considered by the board if the recipient can document to the board's satisfaction that market forces are not allowing for advantageous sales of the approved renewable fuel. A grant recipient shall submit documentation of the previous six-month sales history and marketing attempts to substantiate the grant recipient's request for a temporary waiver. The following conditions apply to requests for a temporary waiver:

(1) A temporary waiver will not be granted during the first six months of a cost-share agreement.

(2) A temporary waiver will not shorten the grant recipient's obligation to use the infrastructure to store and dispense the approved renewable fuel for a minimum of three years or five years. If the board approves a temporary waiver, the duration of the cost-share agreement will be extended by the length of the approved waiver period.

(3) A grant recipient may request a temporary waiver of up to six months. The board may approve one or more six-month waivers, provided the total cumulative time period allowed for temporary waivers shall not exceed two years.

(4) If a state executive order suspending the Iowa Renewable Fuel Standard (RFS) schedule is issued, the board may decide to grant a temporary waiver to all grant recipients. The board will establish the duration of the waiver and provide written notice to all grant recipients of the board's action. When the board determines that a temporary waiver is necessary due to suspension of the Iowa RFS schedule, the three-year or five-year duration of the cost-share agreement will not be extended by the length of the temporary waiver.

[**ARC 7949B**, IAB 7/15/09, effective 6/19/09]

These rules are intended to implement Iowa Code sections 15G.201, 15G.202 and 15G.205, Iowa Code Supplement sections 15G.203 and 15G.204, and 2008 Iowa Acts, House File 2689, and House File 2450, section 6(9)*"f."*

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IOWA FINANCE AUTHORITY[265]

[Prior to 7/26/85, Housing Finance Authority[495]]
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CHAPTER 32
IOWA JOBS PROGRAM

265—32.1(16,83GA,SF376) Purpose. The Iowa jobs board is charged by the Iowa legislature and the governor with establishing, overseeing and providing approval of the administration of the Iowa jobs program. The board will encourage and support public construction projects relating to disaster relief and mitigation and to local infrastructure.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.2(16,83GA,SF376) Definitions. When used in this chapter, the following definitions apply unless the context otherwise requires:

"Authority" or *"IFA"* means the Iowa finance authority.

"Board" means the Iowa jobs board as established in 2009 Iowa Acts, Senate File 376, section 5.

"Disaster" means the severe storms, tornadoes, and flooding that occurred in Iowa between May 25, 2008, and August 13, 2008, and designated by FEMA as FEMA-1763-DR; additionally, the Iowa jobs board may, by resolution, designate an event that occurs subsequent to June 15, 2009, as a disaster.

"Financial feasibility" means the ability of a project, once completed, to be maintained and operated for its useful life with funds either generated by the project itself or from an identifiable source of funds available for such purpose.

"Future flood prevention" means measures intended to mitigate or lessen the damages caused by future flooding.

"Indirect jobs" means jobs created by suppliers of materials used in the construction or operation of the project.

"Induced jobs" means jobs collaterally created throughout the economy by a project as employed workers and firms buy other goods and services.

"Iowa jobs program review committee" or *"review committee"* means the committee established by 2009 Iowa Acts, Senate File 376, section 9(2), and constituted as described in this chapter.

"Local infrastructure" means:

1. Projects relating to disaster rebuilding;
2. Reconstruction and replacement of local public buildings;
3. Flood control and flood protection; and
4. Future flood prevention.

"Local infrastructure" does not include routine, recurring maintenance or operational expenses or leasing of a building, appurtenant structure, or utility without a lease-purchase agreement.

"Local support" means endorsement of a proposed project by local individuals, organizations, or governmental bodies that have a substantial interest in a project.

"Program" means the Iowa jobs program established in 2009 Iowa Acts, Senate File 376, sections 5 to 12.

"Public construction project" means a project for the construction of local infrastructure by a county, city, or public organization.

"Public organization" means a nonprofit organization that sponsors or supports the public needs of one or more local Iowa communities and that was in operation prior to January 1, 2009; provided that (1) such organization is described in Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code and is exempt from federal tax under Section 501(a) of the Internal Revenue Code, and (2) such organization is determined by the board not to be affiliated with or controlled by a for-profit organization.

"Recipient" means an entity under contract with the Iowa jobs board to receive Iowa jobs funds and undertake a funded project.

"Sustainability" means the use, development, and protection of resources at a rate and in a manner that enables people to meet their current needs while allowing future generations to meet their own needs; "sustainability" requires simultaneously meeting environmental, economic and community needs.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.3(16,83GA,SF376) Allocation of funds. All Iowa jobs funds shall be awarded and used as specified in 2009 Iowa Acts, Senate File 376, and these rules. Any portion of an amount allocated for projects that remains unexpended or unencumbered one year after the allocation has been made by the board may be reallocated by the board to another project category, at the discretion of the board. All bond proceeds shall be expended within three years from when the allocation was initially made. The total amount of allocations for future flood prevention, reconstruction and replacement of local public buildings, disaster rebuilding, flood control and flood protection projects (pursuant to the local infrastructure competitive grant program) shall not exceed $165 million for the fiscal year beginning July 1, 2009.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.4(16,83GA,SF376) Local infrastructure competitive grant program. The board shall assist in the development and completion of public construction projects relating to disaster relief and mitigation and to local infrastructure by overseeing and providing approval of the administration of a local infrastructure competitive grant program, as set forth herein.

32.4(1) *Iowa jobs program review committee.* The Iowa jobs program review committee shall comprise five members, consisting of the following members of the Iowa jobs board: three of the general public members, as appointed to the review committee by the Iowa jobs chair, the executive director of the Iowa finance authority (or designee), and the director of Iowa workforce development (or designee). The review committee shall comply with Iowa Code chapter 21 and with Iowa Code sections 69.16 and 69.16A. From its public members, the review committee shall elect a chair and a vice chair. Two-thirds of the review committee members eligible to vote shall constitute a quorum authorized to act in the name of the review committee.

32.4(2) *Eligible applicants.* Eligible applicants for Iowa jobs local infrastructure competitive grant program funds shall be Iowa cities, Iowa counties, and public organizations.

32.4(3) *Eligible projects and forms of assistance.* For a project to be eligible to receive a competitive grant from the board, the project must be a public construction project in the state of Iowa with a demonstrated substantial local, regional, or statewide economic impact. Financial assistance shall be awarded only in the form of grants. An applicant for a competitive grant shall not receive more than $50 million in financial assistance from the Iowa jobs restricted capitals fund.

a. Any award of a competitive grant to a project shall be limited as follows:

(1) Up to 75 percent of the total cost of a project for replacing or rebuilding existing disaster-related damaged property; or

(2) Up to 50 percent of the total cost for all other projects.

b. The authority, with the approval of the chair and vice chair of the Iowa jobs board, shall have the ability to make technical corrections to an award that are within the intent of the terms of a board-approved award.

32.4(4) *Ineligible projects.* The board shall not approve an application for a competitive grant for either of the following purposes:

a. To refinance a loan existing prior to the date of the initial financial assistance application.

b. For a project that has previously received financial assistance under the program, unless the applicant demonstrates that the financial assistance would be used for a significant expansion of such a project.

32.4(5) *Threshold application requirements.* To be considered for a competitive grant, an application shall meet all of the following threshold requirements:

a. Prior to filing an application, the applicant must file, on the form and in the manner prescribed by the authority, a notice of intent to apply not less than 20 days prior to submitting its application;

b. The application must be submitted by an eligible applicant, must be complete and on forms or in the format specified for such purpose by the authority (the authority may, in its discretion, require the use of a Web-based application format), and must be received by the authority by the applicable deadline;

c. The proposed project must be for the development and completion of one or more public construction projects relating to disaster relief and mitigation or to local infrastructure;

d. There must be demonstrated local support for the proposed project;

e. The proposed public construction project must have a demonstrated substantial local, regional, or statewide economic impact; and

f. The application must coordinate any federal funds with state, local, and private funds and shall avoid any duplication of benefits that would limit or cause the loss of federal funding.

Prior to submitting an application to the review committee, the authority may contact the applicant to clarify information contained in the application. An application may be amended one time prior to being sent to the review committee. Applications may be otherwise amended with the approval of a majority of the review committee.

32.4(6) *Application procedure.*

a. Applications shall be reviewed and scored in rounds. The deadline for submission for the first round of applications shall be August 3, 2009. Subsequent rounds shall be quarterly. Applications for each such round shall be due not later than January 1, April 1, July 1, and October 1 of each year, respectively.

b. Subject to availability of funds, applications will be reviewed by IFA staff on an ongoing basis. Applications will be reviewed by staff for completeness and eligibility. If additional information is required, the applicant shall be requested, in writing, to submit additional information. For applications that meet the threshold requirements, authority staff shall submit to the members of the review committee a copy of the application along with a review, analysis, and evaluation of complete applications.

c. The review committee members will score the applications according to the criteria set forth in subrule 32.4(7), and IFA staff shall compile the scores. To be eligible for a grant, a proposed project must receive a minimum score of at least 100 points. The review committee shall meet at least quarterly to review the ratings. Those applications meeting the minimum criteria shall be referred to the Iowa jobs board with a recommendation of final approval, denial, or deferral.

d. Once an application has been referred to the Iowa jobs board, the applicant may, upon request of the applicant and at the discretion of the chair of the board, make a presentation to the board. The board may impose reasonable limitations on the length and format of such presentations.

e. If the board determines that an application should be approved, the board shall send the application to negotiations. Negotiations shall be conducted by IFA staff, who may work in cooperation with members of the Iowa jobs board. The negotiators shall negotiate the terms and conditions of a grant agreement to recommend to the board.

f. Following negotiations, the negotiating team shall report back to the Iowa jobs board as to whether it was able to agree with the applicant on the terms of a proposed grant agreement and, if so, the proposed terms and conditions resulting from the negotiations. The Iowa jobs board shall then vote, without further substantive revision, on whether to agree to the negotiated terms.

g. If the negotiated terms are agreed to by the Iowa jobs board, a grant agreement memorializing the negotiated terms shall be executed by the chair or vice chair of the Iowa jobs board.

h. Application resources for the Iowa jobs program are available at the Iowa jobs Web site: www.ijobsiowa.gov.

i. IFA may provide technical assistance as necessary to applicants. IFA staff may conduct on-site evaluations of proposed projects.

32.4(7) *Application review criteria.* The Iowa jobs program review committee shall evaluate and rank applications based on the following criteria:

a. The total number and quality of jobs to be created and the benefits likely to accrue to areas distressed by high unemployment (0-40 points). The number of jobs created and other measures of economic impact to areas distressed by high unemployment, including long-term tax generation, shall be evaluated. Rating factors for this criterion include, but are not necessarily limited to, the following:

(1) Number of jobs. The number of jobs reasonably projected to be created or retained and the number of hours anticipated for each such job shall be compared and ranked.

(2) Quality of jobs. The wages to be paid for each position to be created or retained, the average benefits (including health benefits) to be provided, as well as other subjective qualitative factors, such as work conditions and safety, shall be compared and ranked.

(3) Other benefits likely to accrue to areas distressed by high unemployment, such as the degree to which the project enhances the quality of life in a region and contributes to the community's efforts to retain and attract a skilled workforce.

In order to be eligible for funding, proposals must score at least 20 points on this criterion.

b. Financial feasibility, including the ability of projects to fund depreciation costs or replacement reserves, and the availability of other federal, state, local, and private sources of funds (0-40 points). The feasibility of the proposed project shall be evaluated. Rating factors for this criterion include, but are not limited to, the following:

(1) A financial analysis of the project, which shall include a description of sources of funding, project budget, and detailed projections of the project's revenues and expenses for the projected useful life of the project;

(2) An analysis of the operational plan, which shall provide detailed information about how the proposed project will be operated and maintained, including a time line for implementing the project;

(3) The availability of other federal, state, local, and private sources of funds for the project.

In order to be eligible for funding, proposals must score at least 20 points on this criterion.

c. Sustainability and energy efficiency. The sustainability and energy efficiency of the proposed project shall be evaluated. Rating factors for this criterion include, but are not limited to, the following:

(1) Sustainability (0-20 points). The extent to which the project has taken sustainability planning principles into consideration.

1. The project shall be evaluated based on the following specific factors:

- Efficient and effective use of land resources and existing infrastructure by encouraging compact development in areas with existing infrastructure or capacity to avoid costly duplication of services and costly use of land; conservation of open space and farmland and preservation of critical environmental areas; and promotion of the safety, livability, and revitalization of existing urban and rural communities. Compact development maximizes public infrastructure investment and promotes mixed uses, greater density, bicycle and pedestrian networks, and interconnection with the existing street grid.
- Provision for a variety of transportation choices, including public transit and pedestrian and bicycle traffic.
- Construction and promotion of developments, buildings, and infrastructure that conserve natural resources by reducing waste and pollution through efficient use of land, energy, water, and materials.
- Capture, retention, infiltration and harvesting of rainfall using storm water best management practices such as permeable pavement, bioretention cells, bioswales, and rain gardens to protect water resources.
- The extent to which project design, construction, and use incorporate renewable energy sources including, but not limited to, solar, wind, geothermal, and biofuels, and support the following state of Iowa plans and goals: (1) office of energy independence's Iowa energy independence plan; and (2) general reduction of greenhouse gas emissions.

2. Alternatively, in lieu of being evaluated on each of the criteria set forth above, projects which receive certification (either platinum level, gold level, silver level, or basic LEED certification) from the United States Green Building Council in the Leadership in Energy and Environmental Design (LEED) Green Building Rating System version 3.0, and which comply with the requirements of ASHRAE 90.1-2007, Energy Standard for Buildings Except Low-Rise Residential Buildings, published by the American Society of Heating, Refrigerating and Air-Conditioning Engineers, 1791 Tullie Circle, N.E., Atlanta, GA 30329, shall receive 20 points.

(2) Energy efficiency (0-20 points). The extent to which the project has taken energy efficiency planning principles into consideration.

1. In the case of new construction, whether the project meets the current state building energy code. The application for the project must include a letter from the engineer or architect to IFA certifying whether the proposed construction meets the current state building energy code. Additionally, the application should address whether the proposed project meets energy star standards. If the project is of such a nature that the current state building energy code does not apply to it, the letter shall so state.

2. In the case of rehabilitation of existing structures, an energy audit conducted by a certified energy rater should be provided on each building prior to the preparation of the final work rehabilitation order to determine the feasibility of meeting the requirements of the current state building energy code and energy star standards prior to the start of the rehabilitation. If it is determined to be feasible to meet the current state building energy code standards and energy star standards, appropriate specifications will be written into the work order. If it is not feasible to meet the requirements of the current state building energy code and energy star standards (or either of them), the application will provide information indicating what effective and cost-effective energy improvements will be included as a part of the rehabilitation project.

d. Benefits for disaster recovery (0-40 points). The likely benefits for disaster recovery of the proposed project shall be evaluated. Wherever applicable, rating factors for this criterion include, but are not limited to, the following:

(1) Whether the proposed project replaces or repairs a structure or facility damaged by the disaster and incorporates measures for reducing or eliminating future disaster losses;

(2) Whether the proposed project would help achieve the community's or region's overall post-disaster recovery vision;

(3) Whether the proposed project benefits the economic recovery of individuals, businesses, or nonprofit organizations.

e. The project's readiness to proceed (0-40 points). The readiness of the project to proceed shall be evaluated. Wherever applicable, rating factors for this criterion include, but are not limited to, the following:

(1) Whether all engineering and architectural work required for construction to begin has been completed;

(2) Whether all financing for the project (other than competitive grant funds awarded under this chapter) has been committed and is available;

(3) Whether all real property interests (including easements and temporary construction easements) necessary for the construction of the project have been acquired;

(4) Whether all necessary governmental approvals, at the federal, state, and local levels (including, but not limited to, zoning variances, building permits, approval from the Army Corps of Engineers, etc.), have been obtained;

(5) Whether the project has demonstrated a reasonable likelihood of incurring at least 10 percent of the project's total projected development cost within three months of execution of the grant award agreement.

f. General scoring criteria.

(1) In instances where a given criterion is not applicable to a proposed project due to the nature of the project, the review committee members may adjust scoring so that the project is not disadvantaged as a result of the inapplicable criterion. For example, if an earthen levee is proposed as a means of flood control, it should not lose points relative to other proposed projects because it does not comply with the current state building energy code (which does not apply to earthen levees).

(2) Any proposed project that is identified in an Iowa great places agreement, pursuant to Iowa Code section 303.3C, shall have an additional two points added to its cumulative point total.

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.5(16,83GA,SF376) Noncompetitive grants.

32.5(1) The board shall award $46,500,000 as follows for disaster relief and mitigation and local infrastructure grants for the following renovation and construction projects, notwithstanding any limitation on the state's percentage participation in funding as contained in Iowa Code section 29C.6(17):

a. For grants to a county with a population between 189,000 and 196,000 in the latest preceding certified federal census, to be distributed as follows:

(1) Ten million dollars for the construction of a new, shared facility between nonprofit human service organizations serving the public, especially the needs of low-income Iowans, including those displaced as a result of the disaster of 2008.

(2) Five million dollars for the construction or renovation of a facility for a county-funded workshop program serving the public and particularly persons with mental illness or developmental disabilities.

b. For grants to a city with a population between 110,000 and 120,000 in the latest preceding certified federal census, to be distributed as follows:

(1) Five million dollars for an economic redevelopment project benefiting the public by improving energy efficiency and the development of alternative and renewable energy technologies.

(2) Ten million dollars for a museum serving the public and dedicated to the preservation of an eastern European cultural heritage through the collection, exhibition, preservation, and interpretation of historical artifacts.

(3) Five million dollars for a theater serving the public and promoting culture, entertainment, and tourism.

(4) Five million dollars for a public library.

(5) Five million dollars for a public works building.

c. One million five hundred thousand dollars, to be distributed as follows:

(1) Five hundred thousand dollars to a city with a population between 600 and 650 in the latest preceding certified federal census, for a public fire station.

(2) Five hundred thousand dollars to a city with a population between 1,400 and 1,500 in the latest preceding certified federal census, for a public fire station.

(3) Five hundred thousand dollars for a city with a population between 7,800 and 7,850, for a public fire station.

32.5(2) Noncompetitive grant awards are contingent upon submission of a plan for each project by the applicable county or city governing board or, in the case of a project submitted pursuant to subparagraph 32.5(1)*"b"*(2), by the board of directors, to the Iowa jobs board no later than September 1, 2009, detailing a description of the project, the plan to rebuild, and the amount or percentage of federal, state, local, or private matching moneys which will be or have been provided for the project. Funds not utilized in accordance with this rule due to failure to submit a plan by the September 1 deadline shall revert to the Iowa jobs restricted capitals fund to be available for local infrastructure competitive grants.

32.5(3) A grant recipient under subparagraph 32.5(1)*"b"*(2) shall not be precluded from applying for a local infrastructure competitive grant pursuant to this rule and 2009 Iowa Acts, Senate File 376, section 9.

[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.6(16,83GA,SF376) General grant conditions. As a condition of receipt of Iowa jobs funds, recipients shall agree, at a minimum, to all of the following:

32.6(1) *Documentation of jobs created or retained.* Following the receipt of grant funds pursuant to this chapter and for two years following the completion of the project, each recipient shall report to the authority quarterly the actual number of jobs created as a result of the project along with other information relating to the quality of such jobs, including hours and wages, as requested by the authority.

32.6(2) *Recipient obligations.* In the event a recipient fails to comply with the requirements of this program or the recipient's grant agreement, the board may cancel the recipient's grant and require the return of any grant funds previously disbursed pursuant to this program. Recipients shall agree to hold harmless and to indemnify the Iowa jobs board, the authority, the state of Iowa, and their officers, employees and agents from any claims, costs or liabilities arising out of the development or operation of the project.

32.6(3) *Grant acknowledgment.* Each project shall recognize in a prominent location and manner the fact that the project was made possible, in part, through a grant from the Iowa jobs program. During the construction period the recognition (including a display of the Iowa jobs logo) may be located on

temporary signage. The completed project shall feature a permanent acknowledgment, such as a plaque or a similar commemoration. Other benefactors of the project may be similarly acknowledged as well.

32.6(4) *Use of Iowa jobs Web site.* All positions that need to be filled for a project shall be posted on Iowa workforce development's Iowa jobs Web site: www.iowajobs.org/.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.7(16,83GA,SF376) Calculation of jobs created. For purposes of this chapter, new employment positions created and filled (or to be created and filled) as a result of the project and existing positions that would not have been continued were it not for Iowa jobs funding shall be counted when estimating the number of jobs to be created during the application process and when counting the number of actual jobs created in post-grant reporting. Both permanent and temporary positions filled by the grantee, a contractor, or a subcontractor (or sub-subcontractor, etc.), including construction work, shall be counted. To be counted, a position must be compensated. Indirect jobs and induced jobs shall not be counted.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.8(16,83GA,SF376) Grant awards. The Iowa jobs board may fund a component of a proposed project if the entire project does not qualify for funding. The board shall review awards made to ensure geographic diversity. In order to promote geographic diversity, the board may defer grant decisions on applications from areas which have received previous grant awards to allow applications from other parts of the state to be considered.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

265—32.9(16,83GA,SF376) Administration of awards.

32.9(1) A grant agreement shall be executed between successful applicants (under both the competitive and noncompetitive grant programs) and the Iowa jobs board. These rules and applicable state laws and regulations shall be part of the contract. The board reserves the right to negotiate wage rates as well as other terms and conditions of the contract.

32.9(2) The recipient must execute and return the contract to the Iowa jobs board within 45 days of transmittal of the final contract from the Iowa jobs board. Failure to do so may be cause for the Iowa jobs board to terminate the award.

32.9(3) Certain projects may require that permits or clearances be obtained from other state, local, or federal agencies before the activity may proceed. Awards may be conditioned upon the timely completion of these requirements.

32.9(4) Awards may be conditioned upon commitment of other sources of funds necessary to complete the project.

32.9(5) Any substantive change to a contract shall be considered an amendment. Substantive changes include time extensions, budget revisions, and significant alterations that change the scope, location, objectives or scale of an approved project. Amendments must be requested in writing by the recipient and are not considered effective until approved by the Iowa jobs board and confirmed in writing by IFA staff following the procedure specified in the contract between the recipient and the Iowa jobs board.
[**ARC 7941B**, IAB 7/15/09, effective 6/15/09]

These rules are intended to implement Iowa Code section 16.5(1)*"r"* and 2009 Iowa Acts, Senate File 376, sections 5 to 12.

[Filed Emergency ARC 7941B, IAB 7/15/09, effective 6/15/09]

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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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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. All physicians who administer vaccines which are available through the Vaccines for Children program to Medicaid members shall enroll in the Vaccines for Children program. Vaccines available through the Vaccines for Children program shall be obtained from the department of public health for Medicaid members. Physicians shall, however, receive reimbursement for the administration of these vaccines to Medicaid members.

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 will not be approved for vaccines which are available through 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.

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 subrule 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.

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 prior to the expected delivery date for premature deliveries. Consent shall be obtained on Form 470-0835 or 470-0835(S), Consent Form, and shall be attached to the claim for payment.

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. Form 470-0835 or 470-0835(S), Consent Form, shall be signed by the individual to be sterilized, the interpreter, when one was necessary, the physician, and 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 lemphocytic 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.

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. 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. 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 to cause anorexia, weight gain, or weight loss, except for lipase inhibitor drugs prescribed for weight loss with prior authorization as provided in paragraph *"a."*

(3) Drugs used for cosmetic purposes or hair growth.

(4) Drugs used to promote smoking cessation, except for varenicline with prior authorization as provided in paragraph *"a"* above and generic, sustained-release bupropion products that are indicated for smoking cessation by the U.S. Food and Drug Administration.

(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)).

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, wash
Calcium carbonate chewable tablets 1250 mg (500 mg elemental calcium)
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
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
Ferrous sulfate tablets 300 mg, 325 mg
Ferrous sulfate elixir 220 mg/5 ml
Ferrous sulfate drops 75 mg/0.6 ml
Ferrous gluconate tablets 300 mg, 325 mg
Ferrous fumarate tablets 325 mg
Guaifenesin 100 mg/5 ml with dextromethorphan 10 mg/5 ml liquid
Ibuprofen suspension 100 mg/5 ml
Ibuprofen tablets 200 mg
Insulin
Lactic acid (ammonium lactate) lotion 12%
Loperamide hydrochloride liquid 1 mg/5 ml
Loperamide hydrochloride tablets 2 mg
Loratadine 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 25 mg, 50 mg, 100 mg, 250 mg, 500 mg
Nicotine gum 2 mg, 4 mg
Nicotine patch 7 mg/day, 14 mg/day and 21 mg/day
Omeprazole magnesium delayed-release tablets 20 mg (base equivalent)
Pediatric oral electrolyte solutions
Permethrin liquid 1%
Pseudoephedrine hydrochloride tablets 30 mg, 60 mg
Pseudoephedrine hydrochloride liquid 30 mg/5 ml
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL liquid
Pseudoephedrine/dextromethorphan 20 mg/10 mg/5 mL elixir
Pseudoephedrine/dextromethorphan 15 mg/5 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 15 mg/7.5 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 30 mg/15 mg/5 mL syrup
Pseudoephedrine/dextromethorphan 7.5 mg/2.5 mg/0.8 mL solution
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 granules 15 mg/5 ml
Sennosides tablets 187 mg
Sodium bicarbonate tablets 325 mg
Sodium bicarbonate tablets 650 mg

Sodium chloride hypertonic ophthalmic ointment 5%

Sodium chloride hypertonic ophthalmic solution 5%

Sodium chloride solution 0.9% for inhalation with metered dispensing valve 90 ml, 240 ml

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.

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 Foundation for Medical Care (IFMC). 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. Readmissions to the same facility due to premature discharge shall not be paid a new DRG. 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 IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50265-7771, 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. 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.

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.

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 panographic-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 prophylasix 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. When prior approval has been given for orthodontic services to treat the most handicapping malocclusions in a manner consistent with "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J.A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

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.

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.

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.

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 rule 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

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
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		
		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		

ICD-9	CATEGORY I	ICD-9	CATEGORY II	ICD-9	CATEGORY III
		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 date of the signature shall be within the certification period.

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.* Home health agencies which 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. Home health agencies may provide Vaccines for Children clinics and be reimbursed for vaccine administration to provide Vaccines for Children program vaccines to Medicaid children in other than the home setting.

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

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

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 150 percent of the purchase price. At the point that total rent paid equals 150 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 the mentally retarded except when a Medicaid-eligible resident of a nursing facility medically needs oxygen for 12 or more hours per day for at least 30 days or more. Medicaid will provide payment to medical equipment and supply dealers to provide oxygen services in a nursing facility 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 a resident of a nursing facility requires oxygen for 12 hours or more per day and the provider and physician, physician assistant, or advanced registered nurse practitioner jointly submit Certificate of Medical Necessity, Form CMS-484, from Medicare or a reasonable facsimile to the Iowa Medicaid enterprise with the monthly billing. The documentation submitted 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.

Oxygen prescribed "PRN" or "as necessary" is not allowed.

(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 shown by medical documentation. The physician's, physician assistant's, or advanced registered nurse practitioner's prescription shall document that other forms of treatment have been tried and have not been successful, and that oxygen therapy is required.

(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.
4. The patient has had a successful trial with an enclosed 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:

Artificial eyes.

Artificial limbs.

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.

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

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

Oral nutritional products. See 78.10(3)*"c"* for prior approval requirements.

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

Ostomy appliances.

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.

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

Tracheotomy tubes.

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(8))

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.

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. Medical supplies are not to be dispensed at any one time for quantities exceeding a three-month supply. 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:

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]

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 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) Remedial services. Payment will be made for remedial services not otherwise covered under this chapter that are designed to minimize or, if possible, eliminate the symptoms or causes of a psychological disorder, subject to the limitations in this rule.

78.12(1) *Covered services.* Medicaid covers the following remedial services:

a. Community psychiatric supportive treatment, which offers intensive interventions to modify psychological, behavioral, emotional, cognitive, and social factors affecting a member's functioning when less intensive remedial services do not meet the member's needs.

(1) Interventions must focus on the member's remedial needs to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(2) Interventions may assist the member in skills such as conflict resolution, problem solving, social skills, interpersonal relationship skills, and communication.

(3) Community psychiatric supportive treatment is covered only for Medicaid members who are aged 20 or under.

(4) Community psychiatric supportive treatment is not intended for members in congregate care.

(5) Community psychiatric supportive treatment is not intended to be provided in a group.

b. Crisis intervention 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.

c. Health or behavior intervention, used 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: conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and communication skills.

(2) The purpose of intervention shall be to minimize or eliminate psychological barriers to the member's ability to effectively manage symptoms associated with a psychological disorder in an age-appropriate manner.

(3) Health or behavior intervention is covered only for Medicaid members aged 20 or under.

d. Rehabilitation program, which consists of interventions to enhance a member's independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize the member's ability to live and participate in the community.

(1) Interventions may address the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Rehabilitation program services are covered only for Medicaid members who are aged 18 or over.

e. Skills training and development, which consists of interventions to enhance independent living, social, and communication skills; to minimize or eliminate psychological barriers to a member's ability to effectively manage symptoms associated with a psychological disorder; and to maximize a member's ability to live and participate in the community.

(1) Interventions may include the following skills for effective functioning with family, peers, and community: communication skills, conflict resolution skills, problem-solving skills, social skills, interpersonal relationship skills, and employment-related skills.

(2) Skills training and development services are covered only for Medicaid members aged 18 or over.

78.12(2) *Excluded services.* Services that are habilitative in nature are not covered as remedial services. 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.

78.12(3) *Coverage requirements.* Medicaid covers remedial services 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. For example, licensed practitioners of the healing arts include physicians (M.D. or D.O.), advanced registered nurse practitioners (ARNP), psychologists (Ph.D. or Psy.D.), independent social workers (LISW), marital and family therapists (LMFT), and mental health counselors (LMHC). For purposes of this rule, the licensed practitioner of the healing arts must be:

(1) Enrolled in the Iowa Plan pursuant to 441—Chapter 88, Division IV; and

(2) Qualified to provide clinical assessment services under the Iowa Plan pursuant to 441—Chapter 88, Division IV (Current Procedural Terminology code 90801).

b. The licensed practitioner of the healing arts has recommended the remedial services as part of a plan of treatment designed to treat the member's psychological disorder. 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. The remedial services provider has prepared a written remedial services implementation plan that has been approved by:

(1) The member or the member's parent or guardian; and

(2) The medical services unit of the Iowa Medicaid enterprise.

78.12(4) *Approval of plan.* The remedial services provider shall submit the treatment plan and the remedial services implementation plan to the Iowa Medicaid enterprise (IME) medical services unit for approval before providing the services.

a. Initial plan. The IME medical services unit shall approve the provider's initial remedial services implementation plan if:

(1) The plan conforms to the medical necessity requirements in subrule 78.12(3);

(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 can demonstrate that the provider possesses the skills and resources necessary to implement the plan, as required in rule 441—77.12(249A);

(5) The plan does not exceed six months' duration; and

(6) The plan requires that written progress notes be submitted no less often than every six weeks to the IME medical services unit.

b. Subsequent plans. The IME medical services unit may approve a subsequent remedial services implementation plan according to the conditions in paragraph *"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.

c. Quality review. The IME medical services unit will establish a quality review process. Reviews will evaluate:

(1) The time elapsed from referral to remedial plan development;

(2) The continuity of treatment;

(3) The affiliation of the licensed practitioner of the healing arts with the remedial services provider;

(4) Gaps in service;

(5) The results achieved; and

(6) Member satisfaction.

78.12(5) *Medical necessity.* Nothing in this rule shall be deemed to exempt coverage of remedial services from the requirement that services be medically necessary. "Medically necessary" means that the service is:

a. Consistent with the diagnosis and treatment of the member's condition;

b. Required to meet the medical needs of the member and is needed for reasons other than the convenience of the member or the member's caregiver;

c. The least costly type of service that can reasonably meet the medical needs of the member; and

d. In accordance with the standards of good medical practice. The standards of good practice for each field of medical and remedial care covered by the Iowa Medicaid program are those standards of good practice identified by:

(1) Knowledgeable Iowa clinicians practicing or teaching in the field; and

(2) The professional literature regarding best practices in the field.

This rule is intended to implement Iowa Code section 249A.4 and 2006 Iowa Acts, House File 2734, section 10, subsection 11.

441—78.13(249A) Transportation to receive medical care. Payment will be approved for transportation to receive services covered under the program, including transportation to obtain prescribed drugs, when all of the following conditions are met.

78.13(1) Transportation costs are reimbursable only when:

a. The source of the care is located outside the city limits of the community in which the member resides; or

b. The member resides in a rural area and must travel to a city to receive necessary care.

78.13(2) Transportation costs are reimbursable only when:

a. The type of care is not available in the community in which the member resides; or

b. The member has been referred by the attending physician to a specialist in another community.

78.13(3) Transportation costs are reimbursable only when there is no resource available to the member through which necessary transportation might be secured free of charge. EXCEPTION: Costs of transportation to obtain prescribed drugs may be reimbursed irrespective of whether free delivery is offered when the prescription drug is needed immediately.

78.13(4) Transportation is reimbursable only to the nearest institution or practitioner having appropriate facilities for the care of the member.

78.13(5) Transportation may be of any type and may be provided from any source.

a. Effective September 1, 2008, when transportation is by car, the maximum payment that may be made will be the actual charge made by the provider for transportation to and from the source of medical care, but not in excess of 34 cents per mile.

b. When public transportation is utilized, the basis of payment will be the actual charge made by the provider of transportation, not to exceed the charge that would be made by the most economical available source of public transportation.

c. In all cases where public transportation is reasonably available to or from the source of care and the member's condition does not preclude its use, public transportation must be utilized. When the member's condition precludes the use of public transportation, a statement to the effect shall be included in the case record.

78.13(6) In the case of a child too young to travel alone, or an adult or child who because of physical or mental incapacity is unable to travel alone, payment subject to the above conditions shall be made for the transportation costs of an escort. The worker is responsible for making a decision concerning the necessity of an escort and recording the basis for the decision in the case record.

78.13(7) When meals and lodging or other travel expenses are required in connection with transportation, payment will be subject to the same conditions as for a state employee and the maximum amount payable shall not exceed the maximum payable to a state employee for the same expenses in connection with official travel within the state of Iowa.

78.13(8) When the services of an escort are required subject to the conditions in subrule 78.13(6), payment may be made for the escort's meals and lodging, when required, on the same basis as for the member.

78.13(9) Payment will not be made in advance to a member or a provider of medical transportation.

78.13(10) Payment for transportation to receive medical care is made to the member with the following exceptions:

a. Payment may be made to the agency that provided transportation if the agency is certified by the department of transportation and requests direct payment. Reimbursement for transportation shall be based on a fee schedule by mile or by trip.

b. In cases where the local office has established that the member has persistently failed to reimburse a provider of medical transportation, payment may be made directly to the provider.

c. In all situations where one of the department's volunteers is the provider of transportation.

78.13(11) Form 470-0386, Medical Transportation Claim, shall be completed by the member and the medical provider and submitted to the local office for each trip for which payment is requested. All trips to the same provider in a calendar month may, at the member's option, be submitted on the same form.

78.13(12) No claim shall be paid if presented after the lapse of 365 days from its accrual unless it is to correct payment on a claim originally submitted within the required period.

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

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 recipient shall have an examination by a physician to determine that the recipient has no condition which would contraindicate the use of a hearing aid. This report shall be made on Form 470-0361, Section A, Report of Examination for a Hearing Aid. The requirement for a physician evaluation shall be waived for recipients 18 years of age and older when the recipient has signed an informed consent statement acknowledging that the recipient:

a. Has been advised that it may be in the recipient's best health interest to receive a medical evaluation from a licensed physician prior to 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 recipient could benefit from the use of a hearing aid. The audiologist shall report audiological testing on Form 470-0361, Section B. 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 recipient could benefit from a hearing aid. The physician or audiologist shall report the hearing aid evaluation on Form 470-0828, Hearing Aid Evaluation/Selection Report. When a hearing aid is recommended for a recipient, the physician or audiologist recommending the hearing aid shall see the recipient at least one time within 30 days subsequent to 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 recipient'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 recipient's condition. The physician, audiologists or hearing aid dispenser shall report the hearing aid selection on Form 470-0828, Hearing Aid Evaluation/Selection Report.

78.14(5) *Travel.* When a recipient is unable to travel to the physician or audiologist because of health reasons, the department shall make payment for travel to the recipient'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 make payment 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 make payment for binaural amplification when:

a. A child needs the aid for speech development, or

b. The aid is needed for educational or vocational purposes, or

c. The aid is for a blind individual.

Payment for binaural amplification shall also be approved where the recipient'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 where lack of binaural amplification poses a hazard to a recipient'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.

(1) Payment for the replacement of a hearing aid less than four years old shall require prior approval except when the recipient 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 78.28(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 recipient 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.

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) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as screening center services. Screening centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Screening centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as rural health center services. Rural health clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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

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) Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as family planning clinic services. Family planning clinics that wish to administer those vaccines for Medicaid members who receive services at the clinic shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Family planning clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as clinic services. Clinics that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Clinics shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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).)

Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as maternal health center services. Maternal health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Maternal health centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

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

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 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 an eligible recipient, that can safely be performed in an outpatient setting as determined by the department upon advice from the department's utilization review and quality assurance firm.

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 an eligible recipient, that can safely be performed in an outpatient setting for Medicaid recipients whose mental, physical, or emotional condition necessitates deep sedation or general anesthesia.

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 covered by the Medicare program as ambulatory surgical center services in connection with Medicare-covered surgical procedures.

78.26(1) Abortion procedures are covered only when criteria in subrule 78.1(17) are met.

78.26(2) Sterilization procedures are covered only when criteria in subrule 78.1(16) are met.

78.26(3) 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, 3737 Woodland Avenue, Suite 500, West Des Moines, Iowa 50265, or in local hospital utilization review offices. (Cross-reference 78.28(6))

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

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.

a. Assignment of payment slot. The number of persons who may be approved for home- and community-based habilitation services is subject to a yearly total to be served. The total is set by the department based on available funds and is contained in the Medicaid state plan approved by the federal Centers for Medicare and Medicaid Services. The limit is maintained through the awarding of payment slots to members applying for services.

(1) The case manager shall contact the Iowa Medicaid enterprise through ISIS to determine if a payment slot is available for each member applying for home- and community-based habilitation services.

(2) When a payment slot is assigned, the case manager shall give written notice to the member.

(3) The department shall hold the assigned payment slot for the member as long as reasonable efforts are being made to arrange services and the member 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 applicant on the waiting list, if applicable. The member must reapply for a new slot.

b. Waiting list for payment slots. When the number of applications exceeds the number of members specified in the state plan and there are no available payment slots to be assigned, the member's application for habilitation services shall be denied. The department shall issue a notice of decision stating that the member's name will be maintained on a waiting list.

(1) The Iowa Medicaid enterprise shall enter the member on a waiting list based on the date and time when the member's request for habilitation services was entered into ISIS. In the event that more than one application is received at the same time, members shall be entered on the waiting list on the basis of the month of birth, January being month one and the lowest number.

(2) When a payment slot becomes available, the Iowa Medicaid enterprise shall notify the member's case manager, based on the member's order on the waiting list. The case manager shall give written notice to the member within five working days.

(3) The department shall hold the payment slot for 20 calendar days to allow the case manager to reapply for habilitation services by entering a program request through ISIS. If a request for habilitation

services has not been entered within 20 calendar days, the slot shall revert for use by the next member on the waiting list, if applicable. The member assigned the slot must reapply for a new slot.

(4) The case manager shall notify the Iowa Medicaid enterprise within five working days of the withdrawal of an application.

c. Notice of decision. 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.

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) A payment slot is not available to the member pursuant to paragraph 78.27(3)*"a."*

(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.* The county board of supervisors of the member's county of legal settlement shall reimburse the department for all of the nonfederal share of the cost of home- and community-based habilitation services provided to an adult member with a chronic mental illness as defined in 441—Chapter 90. The department shall notify the county's central point of coordination administrator through ISIS of the approval of the member's service plan.

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)]

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.

(4) The patient has had a successful trial with an enclosed 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 will be approved when it is determined that a patient has the most handicapping malocclusion. This determination is made in a manner consistent with the "Handicapping Malocclusion Assessment to Establish Treatment Priority," by J. A. Salzmann, D.D.S., American Journal of Orthodontics, October 1968.

(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) Rescinded IAB 6/4/08, effective 5/15/08.

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]

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, or master social worker 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.

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as birth center services. Birth centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Birth centers shall receive reimbursement for the administration of vaccines to Medicaid members.

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

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. Hospital outpatient programs 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. Hospital outpatient programs receive payment via the APC reimbursement for the administration of vaccines to Medicaid members.

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 disrhythmia and be able to initiate emergency action if

necessary. The nurse shall assess and implement a plan of care for cardiac risk factor modification. The nurse shall have at least one year of experience in a coronary care unit.

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

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

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

(3) Admission criteria. Candidates for the program must be referred by the attending physician. The following conditions are eligible for the program:

Postmyocardial infarction (within three months postdischarge).

Postcardiac surgery (within three months postdischarge).

Poststreptokinase.

Postpercutaneous transluminal angioplasty (within three months postdischarge).

Patient with severe angina being treated medically because of client or doctor preference or inoperable cardiac disease.

(4) Physical environment and equipment. A cardiac rehabilitation unit must be an autonomous physical unit specifically equipped with the necessary telemetry monitoring equipment, exercise equipment, and appropriate equipment and supplies for cardiopulmonary resuscitation (CPR). The exercise equipment must have the capacity to measure the intensity, speed, and length of the exercises. The equipment must be periodically inspected and maintained in accordance with the hospital's preventive maintenance program.

(5) Medical records. Medical records for each cardiac rehabilitation patient shall consist of at least the following:

Referral form.

Physician's orders.

Laboratory reports.

Electrocardiogram reports.

History and physical examination.

Angiogram report, if applicable.

Operative report, if applicable.

Preadmission interview.

Exercise prescription.

Rehabilitation plan, including participant's goals.

Documentation for exercise sessions and progress notes.

Nurse's progress reports.

Discharge instructions.

(6) Discharge plan. The patient will be discharged from the program when the physician, staff, and patient agree that the work level is functional for them and little benefit could be derived from further continuation of the program, disrhythmia disturbances are resolved, and appropriate cardiovascular response to exercise is accomplished.

(7) Monitoring of services. The program should be monitored by the hospital on a periodic basis using measuring criteria for evaluating cardiac rehabilitation services provided.

(8) Restrictions and limitations. Payment will be made for a maximum of three visits per week for a period of 12 weeks. Payment beyond 12 weeks is made when documentation indicates that the patient has not reached an exit level.

d. Mental health.

(1) General characteristics. To be covered, mental health services must be prescribed by a physician or certified health service provider in psychology, provided under an individualized treatment plan and reasonable and necessary for the diagnosis or treatment of the patient's condition. This means the services must be for the purpose of diagnostic study or the services must reasonably be expected to improve the patient's condition.

(2) Individualized treatment plan. The individualized written plan of treatment shall be established by a physician or certified health service provider in psychology after any needed consultation with appropriate staff members. The plan must state the type, amount, frequency and duration of the services to be furnished and indicate the diagnoses and anticipated goals. (A plan is not required if only a few brief services will be furnished.)

(3) Supervision and evaluation. Services must be supervised and periodically evaluated by a physician, certified health service provider in psychology, or both within the scopes of their respective practices if clinically indicated to determine the extent to which treatment goals are being realized. The evaluation must be based on periodic consultation and conference with therapists and staff. The physician or certified health service provider in psychology must also provide supervision and direction to any therapist involved in the patient's treatment and see the patient periodically to evaluate the course of treatment and to determine the extent to which treatment goals are being realized and whether changes in direction or services are required.

(4) Reasonable expectation of improvement. Services must be for the purpose of diagnostic study or reasonably be expected to improve the patient's condition. The treatment must at a minimum be designed to reduce or control the patient's psychiatric or psychological symptoms so as to prevent relapse or hospitalization and improve or maintain the patient's level of functioning.

It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness although this may be appropriate for some patients. For many other patients, particularly those with long-term chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing versus discontinuing treatment. Where there is a reasonable expectation that if treatment services were withdrawn, the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion would be met.

(5) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. The number of the above staff employed by the facility must be appropriate to the facility's patient load. The staff may be employees of the hospital, on contract, or the service may be provided through referral.

The diagnostic and treatment staff shall consist of a physician, a psychologist, social workers or counselors meeting the requirements for "mental health professionals" as set forth in rule 441—33.1(225C,230A).

(6) Initial assessment. A comprehensive assessment of the biological, psychological, social, and spiritual orientation of the patient must be conducted, which shall include:

A history of the mental health problem, including age of onset, duration, patterns of symptoms, consequences of symptoms, and responses to previous treatment.

A comprehensive clinical history, including the history of physical problems associated with the mental health problem. Appropriate referral for physical examination for determination of any communicable diseases.

Any history of physical abuse.

A systematic mental health examination, with special emphasis on any change in cognitive, social or emotional functioning.

A determination of current and past psychiatric and psychological abnormality.

A determination of any degree of danger to self or others.

The family's history of mental health problems.

The patient's educational level, vocational status, and job performance history.

The patient's social support network, including family and peer relationship.

The patient's perception of the patient's strengths, problem areas, and dependencies.

The patient's leisure, recreational or vocational interests and hobbies.

The patient's ability to participate with peers in programs and social activities.

Interview of family members and significant others, as available, with the patient's written or verbal permission.

Legal problems if applicable.

(7) Covered services. Services covered for the treatment of psychiatric conditions are:

1. Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses.

2. Occupational therapy services if the services require the skills of a qualified occupational therapist and must be performed by or under the supervision of a licensed occupational therapist or by an occupational therapy assistant.

3. Drugs and biologicals furnished to outpatients for therapeutic purposes only if they are of the type which cannot be self-administered and are not "covered Part D drugs" as defined by 42 U.S.C. Section 1395w-102(e)(1)-(2) for a "Part D eligible individual" as defined in 42 U.S.C. Section 1395w-101(a)(3)(A), including an individual who is not enrolled in a Part D plan.

4. Activity therapies which are individualized and essential for the treatment of the patient's condition. The treatment plan must clearly justify the need for each particular therapy utilized and explain how it fits into the patient's treatment.

5. Family counseling services are covered only if the primary purpose of the counseling is the treatment of the patient's condition.

6. Partial hospitalization and day treatment services to reduce or control a person's psychiatric or psychological symptoms so as to prevent relapse or hospitalization, improve or maintain the person's level of functioning and minimize regression. These services include all psychiatric services needed by the patient during the day.

Partial hospitalization services means an active treatment program that provides intensive and structured support that assists persons during periods of acute psychiatric or psychological distress or during transition periods, generally following acute inpatient hospitalization episodes.

Service components may include individual and group therapy, reality orientation, stress management and medication management.

Services are provided for a period for four to eight hours per day.

Day treatment services means structured, long-term services designed to assist in restoring, maintaining or increasing levels of functioning, minimizing regression and preventing hospitalization.

Service components include training in independent functioning skills necessary for self-care, emotional stability and psychosocial interactions, and training in medication management.

Services are structured with an emphasis on program variation according to individual need.

Services are provided for a period of three to five hours per day, three or four times per week.

7. Partial hospitalization and day treatment for persons aged 20 or under. Payment to a hospital will be approved for day treatment services for persons aged 20 or under if the hospital is certified by the department for hospital outpatient mental health services. All conditions for the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall apply to hospitals. All conditions of the day treatment program for persons aged 20 or under as outlined in subrule 78.16(7) for community mental health centers shall be applicable for the partial hospitalization program for persons aged 20 or under with the exception that the maximum hours shall be 25 hours per week.

(8) Restrictions and limitations on coverage. The following are generally not covered except as indicated:

Activity therapies, group activities, or other services and programs which are primarily recreational or diversional in nature. Outpatient psychiatric day treatment programs that consist entirely of activity therapies are not covered.

Geriatric day-care programs, which provide social and recreational activities to older persons who need some supervision during the day while other family members are away from home. These programs are not covered because they are not considered reasonable and necessary for a diagnosed psychiatric disorder.

Vocational training. While occupational therapy may include vocational and prevocational assessment of training, when the services are related solely to specific employment opportunities, work skills, or work setting, they are not covered.

(9) Frequency and duration of services. There are no specific limits on the length of time that services may be covered. There are many factors that affect the outcome of treatment. Among them are the nature of the illness, prior history, the goals of treatment, and the patient's response. As long as the evidence shows that the patient continues to show improvement in accordance with the individualized treatment plan and the frequency of services is within acceptable norms of medical practice, coverage will be continued.

(10) Documentation requirements. The provider shall develop and maintain sufficient written documentation to support each medical or remedial therapy, service, activity, or session for which billing is made. All outpatient mental health services shall include:

1. The specific services rendered.
2. The date and actual time the services were rendered.
3. Who rendered the services.
4. The setting in which the services were rendered.
5. The amount of time it took to deliver the services.
6. The relationship of the services to the treatment regimen described in the plan of care.
7. Updates describing the patient's progress.

For services that are not specifically included in the patient's treatment plan, a detailed explanation of how the services being billed relate to the treatment regimen and objectives contained in the patient's plan of care and the reason for the departure from the plan shall be given.

e. Pain management.

(1) Approval by commission on accreditation of rehabilitation facilities. In addition to certification by the department, pain management programs must also be approved by the commission on accreditation of rehabilitation facilities (CARF).

(2) General characteristics. A chronic pain management program shall provide coordinated, goal-oriented, interdisciplinary team services to reduce pain, improve quality of life, and decrease dependence on the health care system for persons with pain which interferes with physical, psychosocial, and vocational functioning.

(3) Treatment staff. Each person who provides treatment services shall be determined to be competent to provide the services by reason of education, training, and experience. Professional disciplines which must be represented on the treatment staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a licensed physical therapist and a licensed clinical psychologist or psychiatrist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have had adequate medical evaluation and treatment in the months preceding admission to the program including an orthopedic or neurological consultation if the problem is back pain or a neurological evaluation if the underlying problem is headaches.

The person must be free of any underlying psychosis or severe neurosis.

The person cannot be toxic on any addictive drugs.

The person must be capable of self-care; including being able to get to meals and to perform activities of daily living.

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

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

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

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

(6) Discharge plan. For each patient before discharge, a plan for discharge is designed to provide appropriate continuity of care which meets the following requirements:

The plan for continuing care must describe and facilitate the transfer of the patient and the responsibility for the patient's continuing care to another phase or modality of the program, other programs, agencies, persons or to the patient and the patient's personal support system.

The plan is in accordance with the patient's reassessed needs at the time of transfer.

The plan is developed in collaboration with the patient and, as appropriate and available, with the patient's written verbal permission with the family members.

The plan is implemented in a manner acceptable to the patient and the need for confidentiality.

Implementation of the plan includes timely and direct communication with and transfer of information to the other programs, agencies, or persons who will be providing continuing care.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of three weeks of a structured outpatient treatment program. When documentation indicates that the patient has not reached an exit level, coverage may be extended an extra week.

A repeat of the entire program for any patient will be covered only if a different disease process is causing the pain or a significant change in life situation can be demonstrated.

f. Diabetic education.

(1) Certification by department of public health. In addition to certification by the department for Medicaid, diabetic education programs must also be certified by the department of public health. (See department of public health rules 641—Chapter 9.)

(2) General characteristics. An outpatient diabetes self-management education program shall provide instruction which will enable people with diabetes and their families to understand the diabetes disease process and the daily management of diabetes. People with diabetes must learn to balance their special diet and exercise requirements with drug therapy (insulin or oral agents). They must learn self-care techniques such as monitoring their own blood glucose. And often, they must learn to self-treat insulin reactions, protect feet that are numb and have seriously compromised circulation, and accommodate their regimen to changes in blood glucose because of stress or infections.

(3) Program staff. Each person who provides services shall be determined to be competent to provide the services by reason of education, training and experience. Professional disciplines which must be represented on the staff, either through employment by the facility (full-time or part-time), contract or referral, are a physician (M.D. or D.O.), a registered nurse, a registered dietitian and a licensed pharmacist. The number of staff should be appropriate to the patient load of the facility.

(4) Admission criteria. Candidates for the program shall meet the following guidelines:

The person must have Type I or Type II diabetes.

The person must be referred by the attending physician.

The person shall demonstrate an ability to follow through with self-management.

(5) Health assessment. An individualized and documented assessment of needs shall be developed with the patient's participation. Follow-up assessments, planning and identification of problems shall be provided.

(6) Restrictions and limitations on payment. Medicaid will pay for a diabetic self-management education program. Diabetic education programs will include follow-up assessments at 3 and 12 months without charge. A complete diabetic education program is payable once in the lifetime of a recipient.

g. Pulmonary rehabilitation.

(1) General characteristics. Pulmonary rehabilitation is an individually tailored, multidisciplinary program through which accurate diagnosis, therapy, emotional support, and education stabilizes or reverses both the physio- and psychopathology of pulmonary diseases and attempts to return the patient to the highest possible functional capacity allowed by the pulmonary handicap and overall life situation.

(2) Diagnostic and treatment staff. Each person who provides diagnostic or treatment services shall be determined to be competent to provide the services by reason of education, training, and experience.

Professional disciplines which must be represented by the diagnostic and treatment staff, either through employment by the facility (full-time or part-time), contract, or referral, are a physician (doctor of medicine or osteopathy), a respiratory therapist, a licensed physical therapist, and a registered nurse.

(3) Initial assessment. A comprehensive assessment must occur initially, including:

A diagnostic workup which entails proper identification of the patient's specific respiratory ailment, appropriate pulmonary function studies, a chest radiograph, an electrocardiogram and, when indicated, arterial blood gas measurements at rest and during exercise, sputum analysis and blood theophylline measurements.

Behavioral considerations include emotional screening assessments and treatment or counseling when required, estimating the patient's learning skills and adjusting the program to the patient's ability, assessing family and social support, potential employment skills, employment opportunities, and community resources.

(4) Admission criteria. Criteria include a patient's being diagnosed and symptomatic of chronic obstructive pulmonary disease (COPD), having cardiac stability, social, family, and financial resources, ability to tolerate periods of sitting time; and being a nonsmoker for six months, or if a smoker, willingness to quit and a physician's order to participate anyway.

Factors which would make a person ineligible include acute or chronic illness that may interfere with rehabilitation, any illness or disease state that affects comprehension or retention of information, a strong history of medical noncompliance, unstable cardiac or cardiovascular problems, and orthopedic difficulties that would prohibit exercise.

(5) Plan of treatment. Individualized long- and short-term goals will be developed for each patient. The treatment goals will be based on the problems and needs identified in the assessment and specify the regular times at which the plan will be reassessed.

The patients and their families need to help determine and fully understand the goals, so that they realistically approach the treatment phase.

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

Components of pulmonary rehabilitation to be included are physical therapy and relaxation techniques, exercise conditioning or physical conditioning for those with exercise limitations, respiratory therapy, education, an emphasis on the importance of smoking cessation, and nutritional information.

(6) Discharge plan. Ongoing care will generally be the responsibility of the primary care physician. Periodic reassessment will be conducted to evaluate progress and allow for educational reinforcement.

(7) Restrictions and limitations on payment. Medicaid will pay for a maximum of 25 treatment days. Payment beyond 25 days is made when documentation indicates that the patient has not reached an exit level.

h. Nutritional counseling. Payment will be made for persons aged 20 and under for nutritional counseling provided by a licensed dietitian employed by or under contract with a hospital for a nutritional problem or condition of a degree of severity that nutritional counseling beyond that normally expected as part of the standard medical management is warranted. For persons eligible for the WIC program, a WIC referral is required. Medical necessity for nutritional counseling services exceeding those available through WIC shall be documented.

78.31(5) *Services rendered by advanced registered nurse practitioners certified in family, pediatric, or psychiatric mental health specialties and employed by a hospital.* Rescinded IAB 10/15/03, effective 12/1/03.

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

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 on a monthly payment per enrollee basis will be approved for the case management functions required in 441—Chapter 90.

78.33(1) Payment will be approved for MR/CMI/DD case management services pursuant to 441—Chapter 90 to:

a. Recipients 18 years of age or over with a primary diagnosis of mental retardation, developmental disabilities, or chronic mental illness as defined in rule 441—90.1(249A).

b. Rescinded IAB 1/8/03, effective 1/1/03.

c. Recipients under 18 years of age receiving HCBS MR waiver or HCBS children's mental health waiver services.

78.33(2) Payment for services pursuant to 441—Chapter 90 to recipients under age 18 who have a primary diagnosis of mental retardation or developmental disabilities as defined in rule 441—90.1(249A) and are residing in a child welfare decategorization county shall be made when the following conditions are met:

a. The child welfare decategorization county has entered into an agreement with the department certifying that the state match for case management is available within funds allocated for the purpose of decategorization.

b. The child welfare decategorization county has executed an agreement to remit the nonfederal share of the cost of case management services to the enhanced mental health, mental retardation and developmental disabilities services fund administered by the department.

c. The child welfare decategorization county has certified that the funds remitted for the nonfederal share of the cost of case management services are not federal funds.

78.33(3) Rescinded IAB 10/12/05, effective 10/1/05.

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

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 are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

e. The interdisciplinary team shall determine if the consumer 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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.34(9) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.34(10) *Personal emergency response system.* 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 when the consumer is alone.

a. The required components of the system are:

(1) An in-home medical communications transmitter and receiver.

(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 consumer.

b. The service shall be identified in the consumer's service plan.

c. A unit of service is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year shall be the initial installation and 12 months of service.

78.34(11) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. 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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 selected under subparagraph (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS ill and handicapped waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the following services:

(1) Assist the consumer with developing the consumer's initial and subsequent individual budgets and with making any changes to the individual budget.

(2) Have monthly contact with the consumer 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 consumer.

(5) Assist the consumer with determining whether a potential employee meets the qualifications necessary to perform the job.

(6) Assist the consumer with obtaining a signed consent from a potential employee to conduct background checks if requested by the consumer.

(7) Assist the consumer with negotiating with entities providing services and supports if requested by the consumer.

(8) Assist the consumer with contracts and payment methods for services and supports if requested by the consumer.

(9) Assist the consumer with developing an emergency backup plan. The emergency backup plan shall also 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 consumer. Contact documentation shall include information on the extent to which the consumer's individual budget has addressed the consumer's needs and the satisfaction of the consumer.

k. 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 consumer, 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, if requested.

(6) Verify for the consumer an employee's citizenship or alien status.

(7) Assist the consumer with fiscal and payroll-related responsibilities. Key employer-related tasks include:

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) Purchase from the individual budget workers' compensation or other forms of insurance, as applicable or if requested by the consumer.

(9) Assist the consumer in completing required federal, state, and local tax and insurance forms.

(10) Establish and manage documents and files for the consumer and the consumer's employees.

(11) Monitor timecards, receipts, and invoices to ensure that they are consistent with the individual budget. Keep records of all timecards and invoices for each consumer for a total of five years.

(12) Provide monthly and quarterly status reports for the department, the independent support broker, and the consumer that include a summary of expenditures paid and amount of budget unused.

(13) Establish an accessible customer service system and a method of communication for the consumer and the individual support broker that includes alternative communication formats.

(14) Establish a customer services complaint reporting system.

(15) Develop a policy and procedures manual that is current with state and federal regulations and update as necessary.

(16) Develop a business continuity plan in the case of emergencies and natural disasters.

(17) Provide to the department an annual independent audit of the financial management service.

(18) 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.

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 are set forth in rule 441—171.6(234) or as indicated in the Iowa department of elder affairs Annual Service and Fiscal Reporting Manual.

78.37(2) *Emergency response system.* The emergency response system allows a person experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing preestablished response protocols and personal, medical, and emergency information for each client.

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer 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 persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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 means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. When a restaurant provides the home-delivered meal, the recipient is required to have a nutritional consultation. The nutritional consultation includes contact with the restaurant to explain the dietary needs of the client and explain what constitutes the minimum one-third daily dietary allowance.

A maximum of 14 meals is allowed per week. A unit of service is a meal.

78.37(9) *Home and vehicle modification.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 consumer'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.

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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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.

78.37(16) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS elderly waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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]

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 consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where respite is provided is otherwise reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. The interdisciplinary team shall determine if the consumer 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 persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

78.38(6) *Home-delivered meals.* Home-delivered meals means meals prepared elsewhere and delivered to a waiver recipient at the recipient's residence. Each meal shall ensure the recipient 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. A maximum of 14 meals is allowed per week. 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 are as set forth in rule 441—171.6(234) or the department of elder affairs rule 321—24.7(231).

78.38(8) *Consumer-directed attendant care service.* Consumer-directed attendant care services are service activities performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 (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 consumer'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) 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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS AIDS/HIV waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

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.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Federally qualified health centers that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, vaccine administration is a covered service.

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

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) *Vaccine administration.* Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered services. Advanced registered nurse practitioners who wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. Advanced registered nurse practitioners shall receive reimbursement for the administration of vaccines to Medicaid members.

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.

441—78.41(249A) HCBS MR waiver services. Payment will be approved for the following services to consumers eligible for the HCBS MR waiver services as established in 441—Chapter 83 and as identified in the consumer's service plan. All services include the applicable and necessary instruction, supervision, assistance and support as required by the consumer in achieving the consumer's life goals. The services, amount and supports provided under the HCBS MR 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 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 consumer's home and community, according to the individualized consumer need as identified in the service plan pursuant to rule 441—83.67(249A).

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 those activities which assist a consumer to develop or maintain skills for self-care, self-directedness, and care of the immediate environment.

(2) "Individual advocacy services" means the act or process of representing the individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) "Community skills training services" means activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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; ability to use community resources such as public transportation, libraries, etc., and ability to select foods at the grocery store.

2. Socialization skills training services are those activities which assist a consumer 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 person 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" means activities and expenditures provided to or on behalf of a person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) "Transportation services" means activities and expenditures designed to assist the person to travel from one place to another to obtain services or carry out life's activities. The service excludes transportation to and from work.

(6) "Treatment services" means activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

1. Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

2. Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person'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 consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

c. Services may be provided to a child or an adult. A maximum of three consumers receiving community-supported alternative living arrangements or HCBS MR services may reside in a living unit except providers meeting requirements set forth in 441—paragraph 77.37(14)*"e."*

(1) Consumers may live within the home of their family or legal representative or within other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living within the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Transportation to and from a day program is not a reimbursable service. Maintenance and room and board costs are not reimbursable.

f. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each

consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 14 or more hours per day as an average over a 7-day week and the consumer's individual comprehensive plan or case plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

g. The maximum number of units available per consumer 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 consumer's individual comprehensive plan.

i. Services shall not be simultaneously reimbursed with other residential services, HCBS MR respite, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

78.41(2) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer's home shall not be reimbursable if the living unit where the respite is provided is reserved for another person on a temporary leave of absence.

b. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Payment for respite services shall not exceed $7,050 per the consumer's waiver year.

e. The service shall be identified in the consumer's individual comprehensive plan.

f. Respite services shall not be simultaneously reimbursed with other residential or respite services, HCBS MR waiver supported community living services, Medicaid or HCBS MR nursing, or Medicaid or HCBS MR home health aide services.

g. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

h. The interdisciplinary team shall determine if the consumer 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 system.* The personal emergency response system is an electronic component that transmits a coded signal via digital equipment to a central monitoring station. The electronic device allows a person to access assistance in the event of an emergency when alone.

a. 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 24 hours per day, seven days per week.

(4) Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

b. The service shall be identified in the consumer's individual comprehensive plan.

c. A unit is a one-time installation fee or one month of service.

d. Maximum units per state fiscal year are the initial installation and 12 months of service.

78.41(4) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the

consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 consumer'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 consumer 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 MR 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 consumer's individual comprehensive 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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic

or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. 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 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 MR 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 consumer eligible for the HCBS MR waiver for paid or unpaid employment, but are not job-task oriented. These services include teaching the consumer concepts necessary as job readiness skills, 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 consumer through a state or local education agency.

(2) Vocational rehabilitation services that are otherwise available to the consumer through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer in the HCBS mental retardation 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 (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS mental retardation waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

441—78.42(249A) Rehabilitative treatment services. Rescinded IAB 8/1/07, effective 9/5/07.

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 at the ICF/MR level of care whose county has voluntarily chosen to participate in the HCBS brain injury waiver are eligible for targeted case management and, therefore, 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 consumer's home and community, according to the individualized consumer need as identified in the individual comprehensive plan (ICP) or department case plan. Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 those activities which assist a consumer 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 individual's rights and interests in order to realize the rights to which the individual is entitled and to remove barriers to meeting the individual's needs.

(3) Community skills training services are those activities which assist a person to develop or maintain skills allowing better participation in the community. Services shall focus on the following areas as they are applicable to individuals being served:

1. Personal management skills training services are activities which assist a person to maintain or develop skills necessary to sustain oneself in the physical environment and are essential to the management of one'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 those activities which assist a consumer 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 person 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 person in the areas of personal needs in order to allow the person to function in the least restrictive environment.

(5) Transportation services are those activities and expenditures designed to assist the consumer 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 those activities designed to assist the person to maintain or improve physiological, emotional and behavioral functioning and to prevent conditions that would present barriers to a person's functioning. Treatment services include physical or physiological treatment and psychotherapeutic treatment.

Physiological treatment means activities including medication regimens designed to prevent, halt, control, relieve, or reverse symptoms or conditions which interfere with the normal functioning of the human body. The activities shall be provided by or under the supervision of a health care professional certified or licensed to provide the treatment activity specified.

Psychotherapeutic treatment means activities provided to assist a person in the identification or modification of beliefs, emotions, attitudes, or behaviors in order to maintain or improve the person'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 consumer 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 consumers 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 time periods when another resource is not available.

(2) Supported community living services shall be available at an hourly rate to consumers for whom a daily rate is not established.

(3) Intermittent service shall be provided as defined in rule 441—83.81(249A).

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 three consumers may reside in a living unit, except when the provider meets the requirements set forth in 441—paragraph 77.39(13)*"e."*

(1) Consumers may live in the home of their family or legal representative or in other types of typical community living arrangements.

(2) Consumers of services living with families or legal representatives are not subject to the maximum of three consumers in a living unit.

(3) Consumers may not live in licensed medical or health care facilities or in settings required to be licensed as medical or health care facilities.

(4) Consumers aged 17 or under living in the home of their family, legal representative, or foster families 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.

d. Rescinded IAB 2/5/03, effective 2/1/03.

e. Provider budgets shall reflect all staff-to-consumer ratios and shall reflect costs associated with consumers' specific support needs for travel and transportation, consulting, instruction, and environmental modifications and repairs, as determined necessary by the interdisciplinary team for each consumer. The specific support needs must be identified in the Medicaid case manager's service plan, the total costs shall not exceed $1570 per consumer per year, and the provider must maintain records to support the expenditures. A unit of service is:

(1) One full calendar day when a consumer residing in the living unit receives on-site staff supervision for 19 or more hours during a 24-hour calendar day and the consumer's individual comprehensive plan identifies and reflects the need for this amount of supervision.

(2) One hour when subparagraph (1) does not apply.

f. The maximum numbers of units available per consumer are 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 consumer's individual comprehensive plan.

h. Services shall not be simultaneously reimbursed with other residential services, HCBS brain injury waiver respite, transportation or personal assistance services, Medicaid nursing, or Medicaid home health aide services.

78.43(3) *Respite services.* Respite care services are services provided to the consumer that give temporary relief to the usual caregiver and provide all the necessary care that the usual caregiver would provide during that time period. The purpose of respite care is to enable the consumer to remain in the consumer's current living situation.

a. Services provided outside the consumer'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. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer's interdisciplinary team.

c. A unit of service is one hour.

d. Respite care is not to be provided to persons during the hours in which the usual caregiver is employed except when the consumer is attending a camp. Respite cannot be provided to a consumer whose usual caregiver is a consumer-directed attendant care provider for the consumer.

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 consumer 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 habilitative 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 modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.43(6) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days per week.

d. Current data files at the central monitoring station containing response protocols and personal, medical and emergency information for each consumer.

e. The service shall be identified in the consumer's individual and comprehensive plan.

f. A unit is a one-time installation fee or one month of service.

g. Maximum units per state fiscal year are the initial installation 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.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a brain injury which provide for health and safety of the consumer which are not ordinarily covered by Medicaid, and are not funded by educational or vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine dispensing devices, communication devices, bath aids, and noncovered environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial purchase cost.

a. Consumers may receive specialized medical equipment once per month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and identified in the consumer's individual comprehensive plan.

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 are set forth in rule 441—171.6(234).

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 aimed at preparing a consumer eligible for the HCBS brain injury waiver for paid or unpaid employment, but which are not job task oriented. These services include teaching the consumer concepts necessary as job readiness skills, such as following directions, attending to tasks, task completion, problem solving, and safety and mobility training. 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 more generalized habilitative goals and are reflected in a habilitative plan which focuses on general habilitative rather than specific employment objectives.

Prevocational services do not include 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 individual through a state or local education agency or vocational rehabilitation services which are otherwise available to the individual through a program funded under Section 110 of the Rehabilitation Act of 1973 (29 U.S.C. 730).

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 consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able.

a. The service activities may include helping the consumer 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, eating and feeding but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer and assistance with understanding of 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 consumer in using transportation essential to the health and welfare of the consumer. The cost of the transportation is not included.

b. The service activities may include helping the consumer 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 before accessing the HCBS waiver.

(1) Tube feedings of consumers 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 provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care for or on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker or case manager prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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 services are monitoring and treatment of a medical nature requiring specially trained caregivers beyond what is normally available in a day care setting. The services must be needed to allow the consumer's usual caregivers to be employed or, for a limited period of time, for academic or vocational training of a usual caregiver; due to the hospitalization, treatment for physical or mental illness, or death of a usual caregiver; or during a search for employment by a usual caregiver.

a. Service requirements. Interim medical monitoring and treatment services shall:

(1) Provide experiences for each consumer's social, emotional, intellectual, and physical development;

(2) Include comprehensive developmental care and any special services for a consumer with special needs; and

(3) Include medical assessment, medical monitoring, and medical intervention as needed on a regular or emergency basis.

b. Interim medical monitoring and treatment services may include supervision to and from school.

c. 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.

(4) Interim medical monitoring and treatment services may be provided only in the consumer's home, in a registered group child care home, in a registered family child care home, in a licensed child care center, or during transportation to and from school.

(5) The staff-to-consumer ratio shall not be less than one to six.

d. A unit of service is one hour.

78.43(15) *Consumer choices option.* The consumer choices option provides a consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 (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 consumer'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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS brain injury waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer assumes the risk for this action and shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

This rule is intended to implement Iowa Code section 249A.4.
[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

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) Teleconsultive services. Rescinded IAB 9/6/00, effective 11/1/00.

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 listed below performed by a person to help a consumer with self-care tasks which the consumer would typically do independently if the consumer were otherwise able. The services must be cost-effective and necessary to prevent institutionalization.

Providers must demonstrate proficiency in delivery of the services in the consumer's plan of care. Proficiency must be demonstrated through documentation of prior training or experience or a certificate of formal training. 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. Consumers 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 consumer.

a. 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, eating and feeding assistance but not the cost of meals themselves.

(6) Housekeeping services which are essential to the consumer'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 consumer is on the job site. The cost of transportation for the consumer 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 and accompanying a consumer in using transportation essential to the health and welfare of the consumer, but not the cost of the transportation.

b. 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 consumers 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.

c. A unit of service is 1 hour for up to 7 hours per day or one 8- to 24-hour day provided by an individual or an agency. Each service shall be billed in whole units.

d. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care shall be responsible for selecting the person or agency who will provide the components of the attendant care services to be provided.

e. The consumer, 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 consumer.

f. The service activities may not include parenting or child care on behalf of the consumer.

g. The consumer, parent, guardian, or attorney in fact under a durable power of attorney for health care and the provider shall complete and sign Form 470-3372, HCBS Consumer-Directed Attendant Care Agreement. A copy of the completed agreement shall be attached to the service plan, which is signed by the service worker prior to the initiation of services, and kept in the consumer's and department's records.

h. If the consumer 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 consumer'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 consumer 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 consumer, 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.

78.46(2) *Home and vehicle modifications.* Covered home and vehicle modifications are those physical modifications to the consumer's home or vehicle listed below that directly address the consumer's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the consumer and enable the consumer to function with greater independence in the home or vehicle.

a. Modifications that are necessary or desirable without regard to the consumer'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, roof repair, or adding square footage to the residence, are excluded except as specifically included below. 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 consumer'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 department approval of a binding contract between the enrolled home and vehicle modification provider and the consumer.

f. The contract shall include, at a minimum, the work to be performed, cost, time frame for work completion, and assurance of liability and workers' compensation coverage.

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 service worker shall encumber up to $505 per month within the monthly dollar cap allowed for the consumer until the amount of the modification is reached within the 12-month period.

h. Services shall be included in the consumer's service plan and shall exceed the Medicaid state plan services.

78.46(3) *Personal emergency response system.* The personal emergency response system allows a consumer experiencing a medical emergency at home to activate electronic components that transmit a coded signal via digital equipment over telephone lines to a central monitoring station. The service shall be identified in the consumer's service plan. A unit is a one-time installation fee or one month of service. Maximum units per state fiscal year are the initial installation and 12 months of service. The necessary components of a system are:

a. An in-home medical communications transceiver.

b. A remote, portable activator.

c. A central monitoring station with backup systems staffed by trained attendants 24 hours per day, seven days a week.

d. Current data files at the central monitoring station containing response protocols and personal, medical, and emergency information for each consumer.

78.46(4) *Specialized medical equipment.* Specialized medical equipment shall include medically necessary items for personal use by consumers with a physical disability which provide for the health and safety of the consumer that are not covered by Medicaid, are not funded by vocational rehabilitation programs, and are not provided by voluntary means. This includes, but is not limited to: electronic aids and organizers, medicine-dispensing devices, communication devices, bath aids and noncovered

environmental control units. This includes repair and maintenance of items purchased through the waiver in addition to the initial costs.

a. Consumers may receive specialized medical equipment once a month until a maximum yearly usage of $6,060 has been reached.

b. The need for specialized medical equipment shall be documented by a health care professional as necessary for the consumer's health and safety and shall be identified in the consumer's service plan.

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 consumer with a flexible monthly individual budget that is based on the consumer's service needs. With the individual budget, the consumer shall have the authority to purchase goods and services and may choose to employ providers of services and supports. Components of this service are set forth below.

a. Agreement. As a condition of participating in the consumer choices option, a consumer shall sign Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement, to document that the consumer 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 set for each consumer. The consumer's department service worker or Medicaid targeted case manager shall determine the amount of each consumer's individual budget, based on the services and supports authorized in the consumer's service plan. The consumer 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 consumer 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 (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 consumer's service plan when calculating the value of that service to be included in the individual budget.

(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) Anticipated costs for home and vehicle modification are not subject to the average cost in subparagraph (2) or the utilization adjustment factor in subparagraph (3). Costs for home and vehicle modification may be released in a one-time payment.

(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 consumer must hire an independent support broker and must work with a financial management service that is enrolled as a Medicaid HCBS physical disability waiver services provider.

(1) Before hiring the individual support broker, the consumer shall receive the results of the background check conducted pursuant to 441—subrule 77.30(14).

(2) If the consumer chooses to hire a person who has a criminal record or founded abuse report, the consumer shall acknowledge this information on Form 470-4289, HCBS Consumer Choices Informed Consent and Risk Agreement.

d. Optional service components. A consumer who elects the consumer choices option may purchase the following services and supports, which shall be provided in the consumer'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 consumer remain in the home and community.

(2) Self-directed community supports and employment. Self-directed community supports and employment are services that support the consumer in developing and maintaining independence and community integration.

(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 a need identified in the consumer's service plan. The item or service shall decrease the consumer's need for other Medicaid services, promote the consumer's inclusion in the community, or increase the consumer's safety in the community.

e. Development of the individual budget. The individual support broker shall assist the consumer in developing and implementing the consumer'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. After the initial implementation, the independent support broker shall not be paid for more than 20 hours of service during a 12-month period without prior approval by the department.

(3) The costs of any services and supports chosen by the consumer as described in paragraph *"d."*

f. Budget authority. The consumer 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 with the exception of the independent support broker and the financial management service. 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 identified in the individual budget. Consumers shall not use the individual budget to purchase room and board, sheltered workshop services, child care, or personal entertainment items.

(5) Reallocate funds among services included in the budget.

g. Delegation of budget authority. The consumer 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 consumer.

(3) The consumer shall sign a consent form that designates who the consumer has chosen as a representative and what responsibilities the representative shall have.

(4) The representative shall not be paid for this service.

h. Employer authority. The consumer 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 consumer 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.

i. Employment agreement. Any person employed by the consumer to provide services under the consumer choices option shall sign an employment agreement with the consumer that outlines the employee's and consumer's responsibilities.

j. Responsibilities of the independent support broker. The independent support broker shall perform the services specified in 78.34(13)*"j."*

k. Responsibilities of the financial management service. The financial management service shall perform all of the services specified in 78.34(13)*"k."*

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

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. Vaccines available through the Vaccines for Children program under Section 1928 of the Social Security Act are not covered as local education agency services. Agencies that wish to administer those vaccines to Medicaid members shall enroll in the Vaccines for Children program and obtain the vaccines from the department of public health. However, the administration of vaccines is a covered service.

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.

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 items installed or used within the consumer's home that address specific, documented health, mental health, or safety concerns.

b. A unit of service is one modification or device.

c. For each unit of service provided, the case manager shall maintain in the consumer's case file a signed statement from a mental health professional on the consumer's interdisciplinary team that the service has a direct relationship to the consumer's diagnosis of serious emotional disturbance.

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 consumer 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 consumer and are available on a 24-hour-per-day basis to assume responsibility for the care of the consumer.

a. Respite care shall not be provided to consumers during the hours in which the usual caregiver is employed, except when the consumer is attending a camp.

b. The usual caregiver cannot be absent from the home for more than 14 consecutive days during respite provision.

c. Staff-to-consumer ratios shall be appropriate to the individual needs of the consumer as determined by the consumer'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 consumer. The consumer 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 consumer. The consumer 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 consumers receiving respite. These consumers 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 consumers 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 consumer'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.

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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.

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. Payments to health care providers that are owned or operated by Iowa state or non-state government entities shall not exceed the provider's cost of providing services to Medicaid members. 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. Effective July 1, 2009, 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 based on actual, current costs of operation so as not to exceed reasonable and proper costs by more than 2.5 percent.

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. 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. 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.*

Provider category	Basis of reimbursement	Upper limit
Advanced registered nurse practitioners	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Ambulance	Fee schedule	Ground ambulance: Fee schedule in effect 6/30/08 plus 1%. Air ambulance: Fee schedule in effect 6/30/08 plus 1%.
Ambulatory surgical centers	Base rate fee schedule as determined by Medicare. See 79.1(3)	Fee schedule in effect 6/30/08 plus 1%.
Area education agencies	Fee schedule	Fee schedule in effect 6/30/00 plus 0.7%.
Audiologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Behavioral health services	Fee schedule	Fee schedule.
Birth centers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Chiropractors	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Clinics	Fee schedule	Maximum physician reimbursement rate.
Community mental health centers and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)	Retrospective cost-related. See 79.1(25)	100% of reasonable Medicaid cost as determined by Medicare cost reimbursement principles.
Dentists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Durable medical equipment, prosthetic devices and medical supply dealers	Fee schedule. See 79.1(4)	Fee schedule in effect 6/30/08 plus 1%.
Family planning clinics	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Federally qualified health centers	Retrospective cost-related See 441—88.14(249A)	1. Prospective payment rate as required by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA 2000) or an alternative methodology allowed thereunder, as specified in "2" below. 2. 100% of reasonable cost as determined by Medicare cost reimbursement principles. 3. In the case of services provided pursuant to a contract between an FQHC and a managed care organization (MCO), reimbursement from the MCO shall be supplemented to achieve "1" or "2" above.
HCBS waiver service providers, including:		Except as noted, limits apply to all waivers that cover the named provider.

Provider category	Basis of reimbursement	Upper limit
1. Adult day care	Fee schedule	For AIDS/HIV, brain injury, elderly, and ill and handicapped waivers: 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. For mental retardation waiver: County contract rate or, in the absence of a contract rate, $29.47 per half-day, $58.83 per full day, or $75.00 per extended day.
2. Emergency response system	Fee schedule	Initial one-time fee $49.53. Ongoing monthly fee $38.52.
3. Home health aides	Retrospective cost-related	For AIDS/HIV, elderly, and ill and handicapped waivers: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
4. Homemakers	Fee schedule	Maximum of $19.81 per hour.
5. Nursing care	For elderly and mental retardation waivers: Fee schedule as determined by Medicare.	For elderly waiver: $82.92 per visit. For mental retardation waiver: Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, 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: Cannot exceed $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	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed $296.94 per day.

Provider category	Basis of reimbursement	Upper limit
Basic individual respite	Cost-based rate for home health aide services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate, not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Home care agency:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	$18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Nonfacility care:		
Specialized respite	Retrospectively limited prospective rates. See 79.1(15)	$33.75 per hour not to exceed $296.94 per day.
Basic individual respite	Retrospectively limited prospective rates. See 79.1(15)	18.01 per hour not to exceed $296.94 per day.
Group respite	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Facility care:		
Hospital or nursing facility providing skilled care	Fee schedule	$13.12 per hour not to exceed daily per diem for skilled nursing facility level of care.
Nursing facility	Fee schedule	$13.12 per hour not to exceed daily per diem for nursing facility level of care.
Camps	Retrospectively limited prospective rates. See 79.1(15)	$13.12 per hour not to exceed $296.94 per day.
Adult day care	Fee schedule	$13.12 per hour not to exceed rate for regular adult day care services.
Intermediate care facility for the mentally retarded	Fee schedule	$13.12 per hour not to exceed daily per diem for ICF/MR level of care.
Residential care facilities for persons with mental retardation	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
Foster group care	Fee schedule	$13.12 per hour not to exceed daily per diem rate for child welfare services.
Child care facilities	Fee schedule	$13.12 per hour not to exceed contractual daily per diem.
7. Chore service	Fee schedule	$7.71 per half hour.
8. Home-delivered meals	Fee schedule	$7.71 per meal. Maximum of 14 meals per week.

Provider category	Basis of reimbursement	Upper limit
9. Home and vehicle modification	Fee schedule	For elderly waiver: $1010 lifetime maximum. For mental retardation waiver: $5050 lifetime maximum. For brain injury, ill and handicapped and physical disability waivers: $6060 per year.
10. Mental health outreach providers	Fee schedule	On-site Medicaid reimbursement rate for center or provider. Maximum of 1440 units per year.
11. Transportation	Fee schedule	County contract rate or, in the absence of a contract rate, the rate set by the area agency on aging.
12. Nutritional counseling	Fee schedule	$8.25 per unit.
13. Assistive devices	Fee schedule	$110.05 per unit.
14. Senior companion	Fee schedule	$6.59 per hour.
15. Consumer-directed attendant care provided by:		
Agency (other than an elderly waiver assisted living program)	Fee agreed upon by consumer and provider	$20.20 per hour not to exceed the daily rate of $116.72 per day.
Assisted living program (for elderly waiver only)	Fee agreed upon by consumer and provider	For elderly waiver only: $1,117 per calendar month. Rate must be prorated per day for a partial month, at a rate not to exceed $36.71 per day.
Individual	Fee agreed upon by consumer and provider	$13.47 per hour not to exceed the daily rate of $78.56 per day.
16. Counseling		
Individual:	Fee schedule	$10.79 per unit.
Group:	Fee schedule	$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)	$34.98 per hour, $78.88 per day not to exceed the maximum daily ICF/MR per diem.
19. Supported employment:		
Activities to obtain a job:		
Job development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.

Provider category	Basis of reimbursement	Upper limit
Employer development	Fee schedule	$909 per unit (job placement). Maximum of two units per 12 months.
Enhanced job search	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour and 26 hours per 12 months.
Supports to maintain employment	Retrospectively limited prospective rates. See 79.1(15)	Maximum of $34.98 per hour for all activities other than personal care and services in an enclave setting. Maximum of $19.81 per hour for personal care. Maximum of $6.19 per hour for services in an enclave setting. Total not to exceed $2,883.71 per month. Maximum of 40 units per week.
20. Specialized medical equipment	Fee schedule	$6060 per year.
21. Behavioral programming	Fee schedule	$10.79 per 15 minutes.
22. Family counseling and training	Fee schedule	$43.14 per hour.
23. Prevocational services	Fee schedule	For the brain injury waiver: $37.44 per day. For the mental retardation waiver: County contract rate or, in absence of a contract rate, $48.22 per day.
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	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Home health agency (provided by nurse)	Cost-based rate for nursing services provided by a home health agency	Lesser of maximum Medicare rate in effect 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%, converted to an hourly rate.
Child development home or center	Fee schedule	$13.12 per hour.
25. Residential-based supported community living	Retrospectively limited prospective rates. See 79.1(15)	The maximum daily per diem for ICF/MR.
26. Day habilitation	Fee schedule	County contract rate or, in the absence of a contract rate, $13.21 per hour, $32.15 per half-day, or $64.29 per day.
27. Environmental modifications and adaptive devices	Fee schedule	$6060 per year.
28. Family and community support services	Retrospectively limited prospective rates. See 79.1(15)	$34.98 per hour.
29. In-home family therapy	Fee schedule	$93.63 per hour.
30. Financial management services	Fee schedule	$65.65 per enrolled consumer per month.
31. Independent support broker	Rate negotiated by consumer	$15.15 per hour.

Provider category	Basis of reimbursement	Upper limit
32. Self-directed personal care	Rate negotiated by consumer	Determined by consumer's individual budget.
33. Self-directed community supports and employment	Rate negotiated by consumer	Determined by consumer's individual budget.
34. Individual-directed goods and services	Rate negotiated by consumer	Determined by consumer's individual budget.
Hearing aid dispensers	Fee schedule plus product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
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 6/30/08 plus 1% or maximum Medicaid rate in effect 6/30/08 plus 1%.
2. Private duty nursing and personal care for persons aged 20 or under	Interim fee schedule with retrospective cost settlement	Medicaid rate in effect 6/30/08 plus 1%.
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.

Provider category	Basis of reimbursement	Upper limit
Hospitals (Inpatient)	Prospective reimbursement. See 79.1(5)	Reimbursement rate in effect 6/30/08 plus 1%.
Hospitals (Outpatient)	Prospective reimbursement or hospital outpatient fee schedule. See 79.1(16)*"c"*	Ambulatory payment classification rate or hospital outpatient fee schedule rate in effect 7/01/08.
Independent laboratories	Fee schedule. See 79.1(6)	Medicare fee schedule. 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.	1. Office of Management and Budget rate published in the Federal Register for outpatient visit rate.
	2. Fee schedule for service provided for all other Medicaid members.	2. Fee schedule.
Infant and toddler program providers	Fee schedule	Fee schedule.
Intermediate care facilities for 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 6/30/08 plus 1%.
Local education agency services providers	Fee schedule	Fee schedule.
Maternal health centers	Reasonable cost per procedure on a prospective basis as determined by the department based on financial and statistical data submitted annually by the provider group	Fee schedule in effect 6/30/08 plus 1%.
Nursing facilities: 1. Nursing facility care	Prospective reimbursement. See 441—subrule 81.10(1) and 441—81.6(249A). The percentage of the median used to calculate the direct care excess payment allowance ceiling under 441—81.6(16)*"d"*(1)"1" and (2)"1" is 95% of the patient-day-weighted median. The percentage of the difference used to calculate the direct care excess payment allowance is 0%. The percentage of the median used to calculate the direct care excess payment allowance limit is 10% of the patient-day-weighted median. The percentage of the median used to calculate the non-direct care excess payment allowance ceiling under 441—81.6(16)*"d"* (1)"2" and (2)"2" is 96% of the patient-day-weighted median. The percentage of the difference used to calculate the non-direct care excess payment allowance	See 441—subrules 81.6(4) and 81.6(14) and paragraph 81.6(16)*"f."* The direct care rate component limit under 441—81.6(16)*"f"*(1) and (2) is 120% of the patient-day-weighted median. The non-direct care rate component limit under 441—81.6(16)*"f"* (1) and (2) is 110% of the patient-day-weighted median.

Provider category	Basis of reimbursement	Upper limit
	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	Medicare fee schedule.
Opticians	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Optometrists	Fee schedule. Fixed fee for lenses and frames; other optical materials at product acquisition cost	Fee schedule in effect 6/30/08 plus 1%.
Orthopedic shoe dealers	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Pharmaceutical case management	Fee schedule. See 79.1(18)	Refer to 79.1(18).
Physical therapists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Physicians (doctors of medicine or osteopathy)	Fee schedule. See 79.1(7)*"a"*	Fee schedule in effect 6/30/08 plus 1%.
Anesthesia services	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Podiatrists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.

Provider category	Basis of reimbursement	Upper limit
Prescribed drugs	See 79.1(8)	$4.57 dispensing fee. (See 79.1(8)*"a," "b,"* and *"e."*)
Psychiatric medical institutions for children 1. Inpatient	Prospective reimbursement	Rate based on actual costs on 6/30/07, not to exceed a maximum of $167.19 per day.
2. Outpatient day treatment	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Psychologists	Fee schedule	Fee schedule in effect 6/30/08 plus 1%.
Rehabilitation agencies	Fee schedule	Medicare fee schedule; refer to 79.1(21).
Remedial services	Retrospective cost-related plus 1%. See 79.1(23)	110% of average cost.
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 6/30/08 plus 1%.
State-operated institutions	Retrospective cost-related	
Targeted case management providers	Fee for service with cost settlement. See 79.1(1)*"d."*	Retrospective cost-settled rate.

79.1(3) *Ambulatory surgical centers.* Payment is made for facility services on a fee schedule determined by Medicare. These fees are grouped into eight categories corresponding to the difficulty or complexity of the surgical procedure involved. Procedures not classified by Medicare shall be included in the category with comparable procedures.

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," for rates effective October 1, 2005, shall mean the hospital's cost report with fiscal year end on or after January 1, 2004, and before January 1, 2005, 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.

"Graduate medical education and disproportionate share fund" shall mean 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 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.

"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. Using all applicable claims for the period January 1, 2003, through December 31, 2004, and paid through March 31, 2005, the recalibration for rates effective October 1, 2005, 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 from Medicaid charge data on discharge dates occurring from January 1, 2003, to December 31, 2004, and paid through March 31, 2005. 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 2004 fiscal year and paid through March 31, 2005, 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.

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, using claims and associated DRG weights only 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.

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 preceding calendar 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 year in which rebasing occurs, 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 *"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. Cost report adjustments. Rescinded IAB 6/11/03, effective 7/16/03.

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.

Payment limits as stated in subparagraphs (1) and (2) below are applied in the aggregate during the cost settlement process at the completion of the hospital's fiscal year end. The payment limit stated in subparagraph (3) is applied to aggregate Medicaid payments at the end of the state's fiscal year.

(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.

(2) Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs. The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report. The department shall determine the aggregate payments made to the hospital under the diagnosis-related group methodology and compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount. If the payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

(3) 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.

u. Determination of payment amounts for outpatient hospitalization. Rescinded IAB 7/6/94, effective 7/1/94.

v. Reimbursement of malpractice costs. Rescinded IAB 5/30/01, effective 8/1/01.

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 all 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. 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.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(3), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for direct medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $8,642,112.

(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 July 1, 2005, through June 30, 2006, 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.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it 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.

(4) Qualifying for indirect medical education. 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.

(5) Allocation to fund for indirect medical education. Except as reduced pursuant to subparagraph 79.1(5)*"y"*(6), the total amount of funding that is allocated to the graduate medical education and disproportionate share fund for indirect medical education related to inpatient services for July 1, 2008, through June 30, 2009, is $15,174,101.

(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 July 1, 2005, through June 30, 2006, 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.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for indirect medical education payments from the fund because it 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.

(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).

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.

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.

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.

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.

Information contained in the hospital's available 2004 submitted Medicare cost report is used to determine the hospital's low-income utilization rate and the hospital's Medicaid inpatient utilization rate.

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.

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.

Hospitals qualify for disproportionate share payments from the fund without regard to the facility's status as a teaching facility or bed size.

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 amount of funding that is allocated to the graduate medical education and disproportionate share fund for disproportionate share payments for July 1, 2008, through June 30, 2009, is $7,253,641.

(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 July 1, 2005, through June 30, 2006, 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.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of DRG weights shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of DRG weights shall be updated by a three-year period effective for payments from the fund for July of every third year. 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 fund and supplemental disproportionate share payments pursuant to paragraph 79.1(5)*"ab"* cannot exceed the amount of the federal cap under Public Law 102-234. 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.

(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. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/31/01, effective 1/1/02.

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. Enhanced disproportionate-share payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa hospitals qualifying for enhanced disproportionate-share payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying criteria for enhanced disproportionate-share payments. A hospital qualifies for enhanced disproportionate-share payments if it qualifies for payments for disproportionate share from the graduate medical education and disproportionate-share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. 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. Is a non-state government-owned acute-care teaching hospital located in a county with a population over 350,000.

3. Is an Iowa state-owned hospital for persons with mental illness.

(2) Amount of payment. The total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate share shall not exceed the amount of the state's allotment under Public Law 102-234. In addition, the total amount of disproportionate-share payments from the graduate medical education and disproportionate share fund and enhanced disproportionate-share payments shall not exceed the hospital-specific disproportionate-share caps under Public Law 103-666.

The amount available for enhanced disproportionate-share payments shall be the federal allotment less disproportionate-share payments from the graduate medical education and disproportionate share fund. In the event that the disproportionate-share allotment for enhanced payments is insufficient to pay 100 percent of the cost that is eligible for disproportionate-share payments, the allotment shall be allocated among qualifying hospitals using their eligible cost as an allocation basis.

(3) Final disproportionate-share adjustment. The department's total year-end disproportionate-share obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

ac. Enhanced graduate medical education payments. In addition to payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y,"* payment shall be made to all Iowa hospitals qualifying for enhanced graduate medical education payments. Interim payments based on estimated allowable costs will be paid to qualifying hospitals under this paragraph. Final payments under this paragraph will be determined as follows:

(1) Qualifying for enhanced graduate medical education payments. A hospital shall qualify for enhanced graduate medical education payments if it qualifies to receive both direct and indirect medical education payments from the graduate medical education and disproportionate share fund pursuant to paragraph 79.1(5)*"y"* and meets one of the following conditions:

1. 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; or

2. Is a 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 graduate medical education payments from the graduate medical education and disproportionate share fund and enhanced graduate medical education shall not exceed each hospital's actual medical assistance program graduate medical education costs. The amount paid to each qualifying hospital for enhanced graduate medical education payments shall be the hospital's actual medical assistance program graduate medical education costs less the graduate medical education payments from the graduate medical education and disproportionate share fund.

(3) Final graduate medical education adjustment. The department's total year-end graduate medical education obligation to a qualifying hospital shall be calculated following completion of the desk review or audit of the hospital's Form CMS 2552, Hospital and Hospital Health Care Complex Cost Report.

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. Supplemental payments. Rescinded IAB 7/6/05, effective 7/1/05.

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.

a. Effective June 25, 2005, 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 as the average wholesale price as published by Medi-Span less 12 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 drug and all equivalent products (the average price pharmacies pay to obtain drugs as evidenced by purchase records) adjusted by a multiplier of 1.4, 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. Effective June 25, 2005, reimbursement for covered brand-name prescription drugs shall be the lowest of the following, as of the date of dispensing:

(1) The estimated acquisition cost, defined as the average wholesale price as published by Medi-Span less 12 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 after June 30, 2008, the professional dispensing fee is $4.57 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.

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 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.

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 adjustment.

(3) Providers who do not reimburse revenues exceeding 2.5 percent of actual costs 30 days after notice is given by the department will have the revenues over 2.5 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 July 1, 2008, shall mean the hospital's cost report with fiscal year end on or after January 1, 2006, and before January 1, 2007. 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.

"Graduate medical education and disproportionate share fund" shall mean 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.

"Modifier" means a two-character code that is added to the procedure code to indicate the type of service performed. The modifier allows the reporting hospital to indicate that a performed service or procedure has been altered by some specific circumstance. The modifier may affect payment or may be used for information only.

"Multiple significant procedure discounting" means a reduction of the standard payment amount for an APC to recognize that the marginal cost of providing a second APC service to a patient during a single visit is less than the cost of providing that service by itself.

"Observation services" means a set of clinically appropriate services, such as ongoing short-term treatment, assessment, and reassessment, that is provided before a decision can be made regarding whether a patient needs further treatment as a hospital inpatient or is able to be discharged from the hospital.

"Outpatient hospital services" means preventive, diagnostic, therapeutic, observation, rehabilitation, or palliative services provided to an outpatient by or under the direction of a physician, dentist, or other practitioner by an institution that:

1. Is licensed or formally approved as a hospital by the officially designated authority in the state where the institution is located; and
2. Meets the requirements for participation in Medicare as a hospital.

"Outpatient prospective payment system" or *"OPPS"* means the payment methodology for hospital outpatient services established by this subrule and based on Medicare's outpatient prospective payment system mandated by the Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000.

"Outpatient visit" shall mean those hospital-based outpatient services which are billed on a single claim form.

"Packaged service" means a service that is secondary to other services but is considered an integral part of another service.

"Pass-through" means certain drugs, devices, and biologicals for which providers are entitled to payment separate from any APC.

"Quality improvement organization" or *"QIO"* shall mean the organization that performs medical peer review of Medicaid claims, including review of validity of hospital diagnosis and procedure coding information; completeness, adequacy and quality of care; and appropriateness of prospective payments for outlier cases and nonemergent use of the emergency room. These activities undertaken by the QIO may be included in a contractual relationship with the Iowa Medicaid enterprise.

"Rebasing" shall mean the redetermination of the blended base APC rate using more recent Medicaid cost report data.

"Significant procedure" shall mean the procedure, therapy, or service provided to a patient that constitutes the primary reason for the visit and dominates the time and resources expended during the visit.

"Status indicator" or *"SI"* means a payment indicator that identifies whether a service represented by a CPT or HCPCS code is payable under the OPPS APC or another payment system. Only one status indicator is assigned to each CPT or HCPCS code.

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

(1) A teaching hospital that has approval from the Centers for Medicare and Medicaid Services to receive reasonable cost reimbursement for physician services under 42 CFR 415.160 through 415.162 as amended to October 1, 2007, is eligible for combined billing status if the hospital has filed the approval notice with the Iowa Medicaid enterprise provider cost audit and rate-setting unit. If a teaching hospital elects to receive reasonable cost payment for physician direct medical and surgical services furnished to Medicaid members, those services and the supervision of interns and residents furnishing the care to members are covered as hospital services and are combined with the bill for hospital service. Cost settlement for the reasonable costs related to physician direct medical and surgical services shall be made after receipt of the hospital's financial and statistical report.

(2) A hospital-based ambulance service must be an enrolled Medicaid ambulance provider and must bill separately for ambulance services. EXCEPTION: If the member's condition results in an inpatient admission to the hospital, the reimbursement for ambulance services is included in the hospital's DRG reimbursement rate for the inpatient services.

(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 OPPS APC rates established pursuant to this subrule.
3. Fee schedule rates established pursuant to paragraph 79.1(1)*"c."*

(2) Except as provided in paragraph 79.1(16)*"h,"* outpatient hospital services that have been assigned to an APC with an assigned weight shall be reimbursed based on the APC to which the services provided are assigned. For dates of services beginning on or after July 1, 2008, the department adopts and incorporates by reference the OPPS APCs and relative weights effective January 1, 2008, published on November 27, 2007, as final by the Centers for Medicare and Medicaid Services in the Federal Register at Volume 72, No. 227, page 66579. Relative weights shall be updated pursuant to paragraph 79.1(16)*"j."*

(3) The APC payment is calculated as follows:

1. The applicable APC relative weight is multiplied by the blended base APC rate determined according to paragraph 79.1(16)*"e."*
2. The resulting APC payment is multiplied by a discount factor of 50 percent and by units of service when applicable.
3. For a procedure started but discontinued before completion, the department will pay 50 percent of the APC for the service.

(4) The OPPS APC payment status indicators show whether a service represented by a CPT or HCPCS code is payable under an OPPS APC or under another payment system and whether particular OPPS policies apply to the code. The following table lists the status indicators and definitions for both services that are paid under an OPPS APC and services that are not paid under an OPPS APC.

Indicator	Item, Code, or Service	OPPS Payment Status
A	Services furnished to a hospital outpatient that are paid by Medicare under a fee schedule or payment system other than OPPS, such as: ● Ambulance services. ● Clinical diagnostic laboratory services. ● Diagnostic mammography. ● Screening mammography. ● Nonimplantable prosthetic and orthotic devices. ● Physical, occupational, and speech therapy. ● Erythropoietin for end-stage renal dialysis (ESRD) patients.	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but may be paid under the specific rate or methodology established by other rules (other than outpatient hospital).

	• Routine dialysis services provided for ESRD patients in a certified dialysis unit of a hospital.	
B	Codes that are not paid by Medicare on an outpatient hospital basis	Not paid under OPPS APC. • May be paid when submitted on a bill type other than outpatient hospital. • An alternate code that is payable when submitted on an outpatient hospital bill type (13x) may be available.
C	Inpatient procedures	If covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid as an outpatient hospital service, the service is not paid under OPPS APC. Admit the patient and bill as inpatient care.
D	Discontinued codes	Not paid under OPPS APC or any other Medicaid payment system.
E	Items, codes, and services: • That are not covered by Medicare based on statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not covered by Medicare for reasons other than statutory exclusion and may or may not be covered by Iowa Medicaid; or • That are not recognized by Medicare but for which an alternate code for the same item or service may be available under Iowa Medicaid; or • For which separate payment is not provided by Medicare but may be provided by Iowa Medicaid.	If covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item, code, or service is not paid under OPPS APC or any other Medicaid payment system.
F	Certified registered nurse anesthetist services Corneal tissue acquisition Hepatitis B vaccines	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
G	Pass-through drugs and biologicals	If covered by Iowa Medicaid, the item is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.

H	Pass-through device categories	If covered by Iowa Medicaid, the device is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the device is not paid under OPPS APC or any other Medicaid payment system.
K	Blood and blood products Brachytherapy sources Non-pass-through drugs and biologicals Therapeutic radiopharmaceuticals	If covered by Iowa Medicaid, the item is: ● Paid under OPPS APC with a separate APC payment when both an APC and an APC weight are established. ● Paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c"* when either no APC or APC weight is established. If not covered by Iowa Medicaid, the item is not paid under OPPS APC or any other Medicaid payment system.
L	Influenza vaccine Pneumococcal pneumonia vaccine	If covered by Iowa Medicaid, the vaccine is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the vaccine is not paid under OPPS APC or any other Medicaid payment system.
M	Items and services not billable to the Medicare fiscal intermediary	If covered by Iowa Medicaid, the item or service is not paid under OPPS APC, but is paid based on the Iowa Medicaid fee schedule for outpatient hospital services established pursuant to 79.1(1)*"c."* If not covered by Iowa Medicaid, the item or service is not paid under OPPS APC or any other Medicaid payment system.
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.
Q	Packaged services subject to separate payment under Medicare OPPS payment criteria	Paid under OPPS APC in a separate APC payment based on Medicare OPPS payment criteria. If criteria are not met, payment, including outliers, is packaged into payment for other services; therefore, no separate APC payment is made.
S	Significant procedure, not discounted when multiple	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.

T	Significant procedure, multiple reduction applies	If covered by Iowa Medicaid, the procedure is paid under OPPS APC with separate APC payment subject to multiple reduction. If not covered by Iowa Medicaid, the procedure is not paid under OPPS APC or any other Medicaid payment system.
V	Clinic or emergency department visit	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.
X	Ancillary services	If covered by Iowa Medicaid, the service is paid under OPPS APC with separate APC payment. If not covered by Iowa Medicaid, the service is not paid under OPPS APC or any other Medicaid payment system.

d. Calculation of case-mix indices. Hospital-specific and statewide case-mix indices shall be calculated using all applicable claims with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007.

(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 with dates of service occurring in the period July 1, 2006, through June 30, 2007, paid through September 10, 2007, 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 during the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(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 for the period July 1, 2006, through June 30, 2007, that were paid through September 10, 2007.

(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 that APC payment amounts for out-of-state hospitals may be based on either the Iowa statewide base APC rate or the Iowa blended base APC rate for the out-of-state hospital.

(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) If an out-of-state hospital qualifies for reimbursement for direct medical education under Medicare guidelines, it shall qualify for such reimbursement from the Iowa Medicaid program for services to Iowa Medicaid members.

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. Hospital billing. Rescinded IAB 07/02/08, effective 07/01/08.

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—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. Payment for outpatient services delivered in the emergency room. Rescinded IAB 07/02/08, effective 07/01/08.

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. Payments to a hospital that is owned or operated by state or non-state government shall not exceed the hospital's actual medical assistance program costs.

(1) The department shall perform a cost settlement annually after the desk review or audit of the hospital's cost report.

(2) The department shall determine the aggregate payments made to the hospital under the APC methodology and shall compare this amount to the hospital's actual medical assistance program costs as determined from the audit or desk review of the hospital's cost report. For purposes of this determination, aggregate payments shall include amounts received from the Medicaid program, including graduate medical education payments and outlier payments, as well as patient and third-party payments up to the Medicaid-allowed amount.

(3) If the aggregate payments exceed the hospital's actual medical assistance program costs, the amount by which payments exceed actual costs shall be requested and collected from the hospital.

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 all 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. 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.

(2) Allocation to fund for direct medical education. Except as reduced pursuant to subparagraph 79.1(16)*"v"*(3), the total amount of funding that is allocated to the graduate medical education and

disproportionate share fund for direct medical education related to outpatient services for July 1, 2008, through June 30, 2009, is $2,922,460.

(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 July 1, 2005, through June 30, 2006, 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.

Effective for payments from the fund for July 2006, the state fiscal year used as the source of the count of outpatient visits shall be updated to July 1, 2005, through June 30, 2006. Thereafter, the state fiscal year used as the source of the count of outpatient visits shall be updated by a three-year period effective for payments from the fund for July of every third year.

If a hospital fails to qualify for direct medical education payments from the fund because it 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.

w. Adjustments to the graduate medical education and disproportionate share fund for changes in utilization. Rescinded IAB 10/29/03, effective 1/1/04.

79.1(17) *Reimbursement for home- and community-based services home and vehicle modification.* Payment is made for home and vehicle modifications at the amount of payment to the subcontractor provided in the contract between the supported community living provider and subcontractor. All contracts shall be awarded through competitive bidding, shall be approved by the department, and shall be justified by the consumer's service plan. Payment for completed work shall be made to the supported community living provider.

79.1(18) *Pharmaceutical case management services reimbursement.* Pharmacist and physician pharmaceutical case management (PCM) team members shall be equally reimbursed for participation in each of the four services described in rule 441—78.47(249A). The following table contains the amount each team member shall be reimbursed for the services provided and the maximum number of payments for each type of assessment. Payment for services beyond the maximum number of payments shall be considered on an individual basis after peer review of submitted documentation of medical necessity.

Service	Payment amount	Number of payments
Initial assessment	$75	One per patient
New problem assessment	$40	Two per patient per 12 months
Problem follow-up assessment	$40	Four per patient per 12 months
Preventative follow-up assessment	$25	One per patient per 6 months

79.1(19) *Reimbursement for translation and interpretation services.* Reimbursement for translation and interpretation services shall be made to providers based on the reimbursement methodology for the provider category as defined in subrule 79.1(2).

a. For those providers whose basis of reimbursement is cost-related, translation and interpretation services shall be considered an allowable cost.

b. For those providers whose basis of reimbursement is a fee schedule, a fee shall be established for translation and interpretation services, which shall be treated as a reimbursable service.

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 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.

(5) If a provider fails to submit a cost report that meets the requirement of this paragraph, 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.

(6) A projected cost report shall be submitted when a new remedial services provider enters the program or an existing remedial 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. 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.

(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) Effective July 1, 2009, 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 int he 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)]

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.

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 surveillance and utilization review services 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) Remedial services and rehabilitation services for adults with a chronic mental illness:

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.

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]

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

470-4479 (4/08)

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. Elections will be held the first meeting after the beginning of the calendar year.

b. The term of office shall be two years. Officers shall serve no more than two terms for each office.

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 nominating committee of not less than three members and shall appoint other committees approved by the council.

79.7(2) *Alternates.* Each organization represented may select one alternate as representative when the primary appointee is unable to be present. Alternates may attend any and all meetings of the council, but only one representative of each organization shall be allowed to vote.

79.7(3) *Expenses.* The travel expenses of the public representatives and other expenses, 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.

79.7(4) *Meetings.* The council shall meet at least four times each year. At least two of these meetings shall be with the department of human services. Additional 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 such meetings. 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 alternate and to the executive office of each organization or body represented.

d. Notice shall be made to the representing organization when the member, or alternate, 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.* The medical assistance advisory council shall:

a. Make recommendations on the reimbursement for medical services rendered by providers of services.

b. Assist in identifying unmet medical needs and maintenance needs which affect health.

c. Make recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.

d. Reserved.

e. Reserved.

f. Recommend ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.

g. Advise on such administrative and fiscal matters as the commissioner of the department of human services may request.

h. Advise professional groups and act as liaison between them and the department.

i. Report at least annually to the appointing authority.

j. Perform other functions as may be provided by state or federal law or regulation.

k. Communicate information considered by the council to the member organizations and bodies.

79.7(7) *Responsibilities.*

a. Recommendations of the council shall be advisory and not binding upon the department of human services or the member organizations and bodies. The department will consider all advice and counsel of the council.

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, regulations, 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 and alternates on the council.

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.

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.

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 Surveillance and Utilization Review Services 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.

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[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.

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:

Skilled level of care	Nursing level of care	ICF/MR
$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 consumer. 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:

Skilled level of care	Nursing level of care
$2,631	$1,117

(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]

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 pended 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 MR 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.

"Person with a related condition" means an individual who has 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.

"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.

"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.

441—83.61(249A) Eligibility. To be eligible for HCBS MR 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). Those eligible based on a primary diagnosis of mental retardation must have the diagnosis initially established and recertified as follows:

Age	Initial application to HCBS MR waiver program	Recertification for persons with an IQ range of 54 or below, moderate range of MR or below	Recertification for persons with an IQ range of 55 or above, diagnosis of mild or unspecified range of MR
0 through 17 years	Psychological documentation within three years of the application date substantiating a diagnosis of mental retardation or mental disability equivalent to mental retardation	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every six years and when a significant change occurs	After the initial psychological evaluation which listed the consumer in this range, substantiate a diagnosis of mental retardation or mental disability equivalent to mental retardation every three years and when a significant change occurs
18 through 21 years	• Psychological documentation substantiating diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation within three years prior to age 18, or • Diagnosis of mental retardation or mental disability equivalent to mental retardation made before age 18 and current psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to 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 or a diagnosis of mental disability equivalent to mental retardation, if the last testing date was (1) more than five years ago for consumers with an IQ range of 55 or above or with a diagnosis of mild mental retardation, or (2) more than ten years ago for consumers with an IQ range of 54 or below or with a diagnosis of moderate MR or below	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every ten years and whenever a significant change occurs	Psychological documentation substantiating a diagnosis of mental retardation or a diagnosis of mental disability equivalent to mental retardation every five 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 MR 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 MR 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. Consumers 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 the Functional Assessment Tool, Form 470-3073, and identify the consumer's needs and desires as well as the availability and appropriateness of the services.

b. Consumers not receiving services as set forth in paragraph *"a"* who are applying for the HCBS MR waiver service shall have a department service worker or a case manager paid by the county without Medicaid funds complete the Functional Assessment Tool, Form 470-3073, for the initial level of care determination; establish an initial interdisciplinary team for HCBS MR services; and, with the initial interdisciplinary team, identify the consumer's needs and desires as well as the availability and appropriateness of services.

c. Persons 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 the Functional Assessment Tool, Form 470-3073, 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 470-3073 or other circumstances beyond the worker's control.

g. At initial enrollment the service worker, department QMRP, case manager paid by the county without Medicaid funds, or Medicaid case manager shall establish an HCBS MR 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. 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 Functional Assessment Tool, Form 470-3073.

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

(4) Service plans for consumers 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 or the designee of the county board of supervisors. The service worker, department QMRP, 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 MR program limit.* The number of persons receiving HCBS MR waiver services in the state shall be limited to the number of payment slots provided in the HCBS MR waiver approved by the Centers for Medicare and Medicaid Services (CMS). The department shall make a request to CMS to adjust the program limit annually to be effective each July 1 based upon the county management plans submitted by the state and counties. The department shall also submit a request to CMS for changes to the program limit to be effective January 1 if requested by a county during the month of September.

a. The payment slots are on a county basis for adults with legal settlement in a county and are on a statewide basis for children and adults without a county of legal settlement. These slots shall be available on a first-come, first-served basis.

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.*

a. The county department office shall contact the bureau of long-term care for state cases and children or the central point of coordination administrator for the county of legal settlement for adults to determine if a payment slot is available for all new applications for the HCBS MR program.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau or the county 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 or the county 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 is 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 county department office 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 the request as specified in 83.61(4)*"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. 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. The county central point of coordination administrator (for adults) and the bureau of long-term care (for children and for adults with state case status) 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 for state cases and children or the central point of coordination administrator for the county of legal settlement for adults within five working days of the receipt of an application and of any action on or withdrawal of an application.

441—83.62(249A) Application.

83.62(1) *Application for HCBS MR 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 MR 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 Part A of Form 470-3073, Mental Retardation Functional Assessment Tool, indicating the consumer's choice of care.

d. HCBS MR 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 MR 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]

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 MR 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).

441—83.65(249A) Rescinded IAB 6/5/96, effective 8/1/96.

441—83.66(249A) Allowable services. Services allowable under the HCBS MR 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).

441—83.67(249A) Service plan. A service plan shall be prepared for each HCBS MR 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 or county 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 or county and service worker or case manager are unable to agree on the terms of the services or service cost within 10 days, the department or county has final authority regarding the services and service cost.

d. If a notice of decision is not received from a county within 30 days from the date of request for services, the request shall be sent to the department of human services with documentation verifying the original submission of the request to the county. The department shall send a letter to the county central point of coordination and county board of supervisors requesting a response within 10 days. If no response is received within 10 days, the department will make the decision, as stated in paragraph *"b."*

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. The HCBS MR service is not 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. The HCBS MR 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 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.

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.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—paragraph 25.13(2)*"j."* If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department pursuant to rule 441—83.69(249A).

441—83.70(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the HCBS MR waiver service expenses to adults. The county shall enter into a payment agreement with the department for reimbursement of the nonfederal share of the cost of service provided to HCBS MR waiver adults by input through the Individualualized Services Information System (ISIS).

83.70(1) *County agreement.* The county shall enter into the agreement using the criteria in subrules 83.61(2) and 83.62(1).

83.70(2) *Continuation of services for HCBS MR consumers.* The county shall continue to provide HCBS MR services to consumers with mental retardation who are enrolled in the HCBS MR program on August 1, 1996. The county shall continue to provide HCBS MR services to children who are enrolled in the HCBS MR program after the children turn 18. The state slot for a child in the HCBS MR program will transfer to the county of legal settlement when the child turns 18.

83.70(3) *Continuation of services for children receiving residential-based supported community living services.* The county of legal settlement shall be given the option to continue to provide funding for appropriate services to a child 18 to 21 years of age who is receiving residential-based supported community living services after the child turns 18. The case manager shall notify the county of legal settlement when the child in placement turns 16. For children placed after the age of 16, the case manager shall notify the county of legal settlement at the time of placement.

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. Recipients of the HCBS MR waiver program may be eligible for a rent subsidy program. See 441—Chapter 53.

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 consumer 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 prior to services provision and annually thereafter.

The case manager 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) 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 consumers 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 consumers 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, or for a consumer at the ICF/MR level of care, the designee of the county of legal settlement's board of supervisors, 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. For new applications for people who require the ICF/MR level of care when the county of legal settlement has payment responsibility pursuant to rule 441—83.90(249A), the county department office shall inform the county of legal settlement of the application.

(1) For applicants not currently receiving Medicaid, the county department office shall contact the bureau and notify the county of those applicants for whom the county has payment responsibility 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 and notify the county of those persons for whom the county has payment responsibility 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.

The county shall have financial responsibility for the state share of the costs of services for these consumers as stated in rule 441—83.90(249A). The county shall include these ICF/MR level of care brain-injured consumers in their annual county management plan which is approved by the state.

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 consumers 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, or when a county voluntarily chooses to participate, by the county board of supervisors' designee or the bureau's designee. 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.

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.

The applicant or consumer for whom the county has legal payment responsibility shall be entitled to a review of adverse decisions by the county by appealing to the county pursuant to 441—paragraph 25.13(2)*"j."* If dissatisfied with the county's decision, the applicant or consumer may file an appeal with the department pursuant to rule 441—83.69(249A).

441—83.90(249A) County reimbursement. The county board of supervisors of the consumer's county of legal settlement shall reimburse the department for all the nonfederal share of the cost of brain injury waiver services to consumers at the ICF/MR level of care with legal settlement in the county who are coming onto the waiver from an ICF/MR facility or who have been receiving other services for which the county has been financially responsible or would become liable due to the person's reaching the age of majority. The county shall enter into a payment agreement with the department for reimbursement of the nonfederal share of the cost of services provided to adults who meet the criteria stated above by input through the Individualized Services Information System (ISIS). Waiver slots for these persons shall be identified in the county management plan submitted to the department pursuant to 441—Chapter 25.

The county shall enter into the agreement using the criteria in subrule 83.82(2).

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 MR 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.

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 90
TARGETED CASE MANAGEMENT

PREAMBLE

These rules define and structure medical assistance targeted case management services provided in accordance with Iowa Code section 225C.20 for Medicaid members with mental retardation, chronic mental illness, or a developmental disability and members eligible for the home- and community-based services (HCBS) children's mental health waiver. Provider accreditation standards are set forth in 441—Chapter 24.

Case management is a method to manage multiple resources effectively for the benefit of Medicaid members. The service is designed to ensure the health, safety, and welfare of members by assisting them in gaining access to appropriate and necessary medical services and interrelated social, educational, housing, transportation, vocational, and other services.

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441—90.1(249A) Definitions.

"Adult" means a person 18 years of age or older on the first day of the month in which service begins.

"Child" means a person under 18 years of age.

"Chronic mental illness" means the condition present in adults who have a persistent mental or emotional disorder that seriously impairs their functioning relative to such primary aspects of daily living as personal relations, living arrangements, or employment.

People with chronic mental illness typically meet at least one of the following criteria:

1. They have undergone psychiatric treatment more intensive than outpatient care more than once in a lifetime (e.g., emergency services, alternative home care, partial hospitalization, or inpatient hospitalization).
2. They have experienced at least one episode of continuous, structured supportive residential care other than hospitalization.

In addition, people with chronic mental illness typically meet at least two of the following criteria on a continuing or intermittent basis for at least two years:

1. They are unemployed, or employed in a sheltered setting, or have markedly limited skills and a poor work history.
2. They require financial assistance for out-of-hospital maintenance and may be unable to procure this assistance without help.
3. They show severe inability to establish or maintain a personal social support system.
4. They require help in basic living skills.
5. They exhibit inappropriate social behavior that results in demand for intervention by the mental health or judicial system.

In atypical instances, a person who varies from these criteria could still be considered to be a person with chronic mental illness.

For purposes of this chapter, people with mental disorders resulting from Alzheimer's disease or substance abuse shall not be considered chronically mentally ill.

"Department" means the department of human services.

"Developmental disability" means a severe, chronic disability that:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the age of 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated.

"Major incident" means an occurrence involving a member using the service that:

1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; or
2. Results in a member's death or the death of another person; or
3. Requires emergency mental health treatment for the member; or
4. Requires the intervention of law enforcement; or
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; or
6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3."
7. Involves a member's location being unknown by provider staff who are assigned protective oversight.

"Medical institution" means an institution that is organized, staffed, and authorized to provide medical care as set forth in 42 Code of Federal Regulations 435.1009, as amended to October 1, 2001. A residential care facility is not a medical institution.

"Member" means a person who has been determined to be eligible for Medicaid under 441—Chapter 75.

"Mental retardation" means a diagnosis of mental retardation which:

1. Is made only when the onset of the person's condition was before the age of 18 years;
2. Is based on an assessment of the person's intellectual functioning and level of adaptive skills;
3. Is made by 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; and
4. Is made in accordance with the criteria provided in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

"Rights restriction" means limitations not imposed on the general public in the areas of communication, mobility, finances, medical or mental health treatment, intimacy, privacy, type of work, religion, place of residence, and people with whom a person may share a residence.

"Targeted case management" means services furnished to assist members who are part of a targeted population and 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 services in order to ensure the health, safety, and welfare of the members. Case management is provided to a member on a one-to-one basis by one case manager.

"Targeted population" means people who meet one of the following criteria:

1. An adult who is identified with a primary diagnosis of mental retardation, chronic mental illness or developmental disability; or
2. A child who is eligible to receive HCBS mental retardation waiver or HCBS children's mental health waiver services according to 441—Chapter 83.

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441—90.2(249A) Eligibility. A person who meets all of the following criteria shall be eligible for targeted case management:

90.2(1) The person is eligible for Medicaid or is conditionally eligible under 441—subrule 75.1(35).

90.2(2) The person is a member of the targeted population.

90.2(3) The person resides in a community setting or qualifies for transitional case management as set forth in subrule 90.5(3).

90.2(4) The person has applied for targeted case management in accordance with the policies of the provider.

90.2(5) The person's need for targeted case management has been determined in accordance with rule 441—90.3(249A).
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441—90.3(249A) Determination of need for service.

90.3(1) *Authorization required.* Rescinded IAB 7/15/09, effective 7/1/09.

90.3(2) *Need for service.* Assessment of the need for targeted case management is required at least annually as a condition of payment under the medical assistance program. The case management provider shall determine the initial and ongoing need for service based on diagnostic reports, documentation of provision of services, and information supplied by the member and other appropriate sources. The evidence shall be documented in the member's file and shall demonstrate that all of the following criteria are met:

a. The member has a need for targeted case management to manage needed medical, social, educational, housing, transportation, vocational, and other services for the benefit of the member.

b. The member has functional limitations and lacks the ability to independently access and sustain involvement in necessary services.

c. The member is not receiving other paid benefits under the medical assistance program or under a Medicaid managed health care plan that serve the same purpose as targeted case management.

90.3(3) *Managed health care.* For members receiving targeted case management under the Iowa plan for behavioral health as described in 441—Chapter 88, Division IV, the department delegates authorization and determination of need for service to the Iowa plan contractor.

a. The Iowa plan contractor shall determine the need for targeted case management services according to the criteria in subrule 90.3(2).

b. The Iowa plan contractor is not required to pay for targeted case management services that it has not authorized or that are provided during a month of Medicaid ineligibility.

90.3(4) *Transition authorization.* Rescinded IAB 7/15/09, effective 7/1/09.
[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.4(249A) Application. The provider shall process an application for targeted case management no later than 30 days after receipt of the application. The provider shall refer the applicant to the department's service unit if other services are needed or requested.

90.4(1) *Application process and documentation.* The application shall include the member's name, the nature of the request for services, and a summary of any evaluation activities completed. The provider shall inform the applicant in writing of the applicant's right to choose the provider of case management services and, at the applicant's request, shall provide a list of other case management agencies from which the applicant may choose. The provider shall maintain this documentation for at least five years.

90.4(2) *Application decision.* The provider shall inform the applicant or the applicant's legally authorized representative of any decision to approve, deny, or delay the service in accordance with notification requirements at 441—subrule 7.7(1).

90.4(3) *Delayed services.* The application shall be approved and the member put on the referral list for assignment to a case manager when targeted case management cannot begin immediately because there is no opening on a caseload. The provider shall notify the applicant or the applicant's legally authorized representative in writing of approval and placement on the referral list. If an applicant is on a referral list for more than 90 days from the date of application, this shall be considered a denial of service.

90.4(4) *Denying applications.* The provider shall deny applications for service when:

a. The applicant is not currently eligible for Medicaid; or

b. The applicant does not meet the eligibility criteria in rule 441—90.2(249A); or

c. The applicant or the applicant's legally authorized representative withdraws the application; or

d. The applicant does not provide information required to process the application; or

e. The applicant is receiving targeted case management from another Medicaid provider; or

f. The applicant does not have a need for targeted case management.
[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.5(249A) Service provision.

90.5(1) *Covered services.* The following shall be included in the assistance that case managers provide to members in obtaining services:

a. Assessment. The case manager shall perform a comprehensive assessment and periodic reassessment of the member's individual needs using Form 470-4694, Targeted Case Management Comprehensive Assessment, to determine the need for any medical, social, educational, housing, transportation, vocational or other services. The comprehensive assessment shall address all of the member's areas of need, strengths, preferences, and risk factors, considering the member's physical and social environment. A face-to-face reassessment must be conducted at a minimum annually and more frequently if changes occur in the member's condition. The assessment and reassessment activities include the following:

(1) Taking the member's history, including current and past information and social history in accordance with 441—subrule 24.4(2), and updating the history annually.

(2) Identifying the needs of the member and completing related documentation.

(3) Gathering information from other sources, such as family members, medical providers, social workers, legally authorized representatives, and others as necessary to form a complete assessment of the member.

b. Service plan. The case manager shall develop and periodically revise a comprehensive service plan based on the comprehensive assessment, which shall include a crisis intervention plan based on the risk factors identified in the risk assessment portion of the comprehensive assessment. The case manager shall ensure the active participation of the member and work with the member or the member's legally authorized representative and other sources to choose providers and develop the goals. This plan shall:

(1) Document the parties participating in the development of the plan.

(2) Specify the goals and actions to address the medical, social, educational, housing, transportation, vocational or other services needed by the member.

(3) Identify a course of action to respond to the member's assessed needs, including identification of all providers, services to be provided, and time frames for services.

(4) Document services identified to meet the needs of the member which the member declined to receive.

(5) Include an individualized crisis intervention plan that identifies the supports available to the member in an emergency. A crisis intervention plan shall identify:

1. Any health and safety issues applicable to the individual member based on the risk factors identified in the member's comprehensive assessment.

2. An emergency backup support and crisis response system, including emergency backup staff designated by providers, to address problems or issues arising when support services are interrupted or delayed or the member's needs change.

(6) Include a discharge plan.

(7) Be revised at least annually, and more frequently if significant changes occur in the member's medical, social, educational, housing, transportation, vocational or other service needs or risk factors.

c. Referral and related activities. The case manager shall perform activities to help the member obtain needed services, such as scheduling appointments for the member, and activities that help link the member with medical, social, educational, housing, transportation, vocational or other service providers or programs that are capable of providing needed services to address identified needs and risk factors and to achieve goals specified in the service plan.

d. Monitoring and follow-up. The case manager shall perform activities and make contacts that are necessary to ensure the health, safety, and welfare of the member and to ensure that the service plan is effectively implemented and adequately addresses the needs of the member. At a minimum, monitoring shall include assessing the member, the places of service (including the member's home when applicable), and all services. Monitoring may also include review of service provider documentation. Monitoring shall be conducted to determine whether:

(1) Services are being furnished in accordance with the member's service plan, including the amount of service provided and the member's attendance and participation in the service.

(2) The member has declined services in the service plan.

(3) Communication is occurring among all providers to ensure coordination of services.

(4) Services in the service plan are adequate, including the member's progress toward achieving the goals and actions determined in the service plan.

(5) There are changes in the needs or status of the member. Follow-up activities shall include making necessary adjustments in the service plan and service arrangements with providers.

e. Contacts. Case management contacts shall occur as frequently as necessary and shall be conducted and documented as follows:

(1) The case manager shall have at least one face-to-face contact with the member every three months.

(2) The case manager shall have at least one contact per month with the member, the member's legally authorized representative, the member's family, service providers, or other entities or individuals. This contact may be face-to-face or by telephone. The contact may also be by written communication, including letters, E-mail, and fax, when the written communication directly pertains to the needs of the member. A copy of any written communication must be maintained in the case file.

(3) The case manager may bill for contacts with non-eligible persons if the contacts are directly related to identifying the member's needs and care as necessary for the purpose of helping the member access services, identifying needs and supports to assist the member in obtaining services, providing case managers with useful feedback, and alerting case managers to changes in the member's needs.

(4) When applicable, documentation of case management contacts shall include:

1. The name of the service provider.

2. The need for and occurrences of coordination with other case managers within the same agency or of referral or transition to another case management agency.

90.5(2) *Exclusions.* Payment shall not be made for activities otherwise within the definition of case management when any of the following conditions exist:

a. The activities are an integral component of another covered Medicaid service.

b. The activities constitute the direct delivery of underlying medical, social, educational, housing, transportation, vocational or other services to which a member has been referred. Such services include, but are not limited to:

(1) Services under parole and probation programs.

(2) Public guardianship programs.

(3) Special education programs.

(4) Child welfare and child protective services.

(5) Foster care programs.

c. The activities are integral to the administration of foster care programs, including but not limited to the following:

(1) Research gathering and completion of documentation required by the foster care program.

(2) Assessing adoption placements.

(3) Recruiting or interviewing potential foster care parents.

(4) Serving legal papers.

(5) Home investigations.

(6) Providing transportation.

(7) Administering foster care subsidies.

(8) Making placement arrangements.

d. The activities for which a member may be eligible are integral to the administration of another nonmedical program, such as a guardianship, child welfare or child protective services, parole, probation, or special education program, except for case management that is included in an individualized education program or individualized family service plan consistent with Section 1903(c) of the Social Security Act.

e. The activities duplicate institutional discharge planning.

90.5(3) *Transition to a community setting.* Case management services may be provided to a member transitioning to a community setting during the 60 days before the member's discharge from a medical institution when the following requirements are met:

a. The member is an adult who qualifies for targeted case management under a targeted population. Transitional case management is not an allowable service under the HCBS brain injury waiver, the HCBS elderly waiver, or HCBS habilitation services.

b. Case management services shall be coordinated with institutional discharge planning, but shall not duplicate institutional discharge planning.

c. The amount, duration, and scope of case management services shall be documented in the member's plan of care, which must include case management services before and after discharge, to facilitate a successful transition to community living.

d. Payment shall be made only for services provided by community case management providers.

e. Claims for reimbursement for case management shall not be submitted until the member's discharge from the medical institution and enrollment in community services.

90.5(4) *Rights restrictions.* Member rights may be restricted only with the consent of the member or the member's legally authorized representative and only if the service plan includes:

a. Documentation of why there is a need for the restriction;

b. A plan to restore those rights or a reason why restoration is not necessary or appropriate; and

c. Documentation that periodic evaluations of the restriction are conducted to determine continued need.

90.5(5) *Documentation.* Service documentation shall also meet the requirements set forth in rule 441—79.3(249A) and 441—subrule 24.4(4).

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441—90.6(249A) Terminating services.

90.6(1) Targeted case management shall be terminated when:

a. The member does not meet eligibility criteria under rule 441—90.2(249A); or

b. The member has achieved all goals and objectives of the service; or

c. The member has no current need for targeted case management; or

d. The member receiving targeted case management based on eligibility under an HCBS waiver is no longer eligible for the waiver; or

e. The member or the member's legally authorized representative requests termination; or

f. The member is unwilling or unable to accept further services; or

g. The member or the member's legally authorized representative fails to provide access to information necessary for the development of the service plan or implementation of targeted case management.

90.6(2) The provider shall notify the member or the member's legally authorized representative in writing of the termination of targeted case management, in accordance with 441—subrule 7.7(1).

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.7(249A) Appeal rights.

90.7(1) *Appeal to the provider.* After notice of an adverse decision by the provider of targeted case management, the member or the member's representative may request an appeal as provided in the appeal process established by the provider agency.

90.7(2) *Appeal to the department.* After notice of an adverse decision by the department pertaining to authorization and need for service, the member or the member's representative may request reconsideration by the department by sending a letter to the department not more than 30 days after the date of the notice of adverse decision. The member or the member's representative may appeal an adverse reconsideration decision by the department as provided in 441—Chapter 7.

90.7(3) *Appeal to the managed health care contractor.* After notice of an adverse decision by a managed health care plan, the member or the member's representative may request a review as provided in rule 441—88.68(249A).

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

441—90.8(249A) Provider requirements.

90.8(1) *Incident reporting.*

a. When a major incident occurs during the provision of case management services:

(1) The case management provider shall notify the following persons of the incident by the end of the next calendar day after the incident:

1. The case management supervisor.
2. The member's legally authorized representative.

(2) By the end of the next calendar day after the incident, the case manager who observed the incident shall also report as much information as is known about the incident to the 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 case management 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 case manager 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) The case manager shall monitor the situation as required in paragraph 90.5(1)*"d"* to ensure the member's needs continue to be met. Submission of the initial report will generate a workflow in the Individualized Services Information System (ISIS) for follow-up by the case manager.

(5) The case managment provider shall maintain the completed report in a centralized file, with a notation in the member's file.

b. When an incident report for a major incident is received from any provider, the case manager shall monitor the situation as required in paragraph 90.5(1)*"d"* to ensure the member's needs continue to be met.

c. When any major incident occurs, the case manager shall reevaluate the risk factors identified in the risk assessment portion of the comprehensive assessment as required in paragraph 90.5(1)*"a"* in order to ensure the continued health, safety, and welfare of the member.

90.8(2) *Emergency coverage.* Effective October 1, 2009, a provider of case management shall have an on-call system to ensure that, in the event of an emergency, members have access to a case manager 24 hours per day, including weekends and holidays. Expectations and parameters for emergency coverage are as follows:

a. The emergency on-call system should be one component of the member's individualized crisis intervention plan and should not be the only emergency resource for the member. The system should not replace emergency services such as 911, crisis intervention lines, or emergency services from provider agencies.

b. The case manager should never provide direct service, but rather is expected to arrange and coordinate services to make sure the member is safe.

c. Case management providers may screen calls to identify nonemergency calls that can wait until regular business hours or to divert calls to other resources when appropriate.

d. Time spent on responding to calls is billable time for the case management provider. Overhead costs may be included in the case management rate as an indirect cost.

90.8(3) *Quality assurance.* Providers shall cooperate with quality assurance activities conducted by the Iowa Medicaid enterprise to ensure the health, safety, and welfare of Medicaid members. These activities may include, but are not limited to:

a. Postpayment reviews of case management services,
b. Review of incident reports,
c. Review of reports of abuse or neglect, and
d. Technical assistance in determining the need for service.

[**ARC 7957B**, IAB 7/15/09, effective 7/1/09]

These rules are intended to implement Iowa Code sections 249A.4, 249A.26, and 249A.27.

[Filed emergency 12/12/02 after Notice 10/16/02—published 1/8/03, effective 1/1/03][1]
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[1] January 1, 2003, effective date of 90.2(5) and 90.3 delayed 70 days by the Administrative Rules Review Committee at a special meeting held December 19, 2002.

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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AIR EMISSIONS REDUCTION ASSISTANCE PROGRAM

567—35.1(455B) Purpose. The purpose of this program is to provide financial assistance to eligible applicants for the purpose of reducing air pollution emissions.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.2(455B) Definitions. For the purposes of this chapter, the following definitions shall apply:

"Applicant" means any unit of state or local government, public or private group, business or individual.

"Cost share" means the applicant's share of proposed eligible project costs.

"Department" means the Iowa department of natural resources.

"Eligible costs" means costs directly related to the eligible project and for which financial assistance moneys may be used.

"Eligible project" means any project which, when implemented, will reduce air emissions.

"Financial assistance" means monetary assistance awarded under these rules to an applicant in the form of a grant or loan.

"Grant" means an award of assistance with the expectation that, with the fulfillment of the conditions of the award, repayment of funds is not required.

"Loan" means an award of financial assistance with the requirement that the award be repaid, including interest as identified in the written agreement between the department and the recipient. A "deferred loan" is one for which repayment of principal or interest, or both, is not required for a specified period of time. A "forgivable loan" is one for which repayment is eliminated in part or entirely if the borrower satisfies specified conditions.

"Recipient" means any applicant selected to receive financial assistance under these rules.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.3(455B) Role of the department of natural resources. The department is responsible for the administration of the program and for disbursement of funds to eligible projects receiving financial assistance under these rules.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.4(455B) Eligible projects. The department may provide financial assistance to applicants for projects that are consistent with the purpose of this program.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.5(455B) Forms. Applicants shall submit proposed eligible projects on application forms provided by the department. The applications are considered public records.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.6(455B) Project selection. The director has sole discretion to determine which eligible projects will receive an award of moneys under this program. Emphasis in selecting eligible projects will be placed on the amount of air pollution emissions reductions anticipated, cost-effectiveness, and the proposed location of the eligible project. Proposed eligible projects must be in compliance with all applicable state and federal statutes and rules. The director shall evaluate the proposals, and applicants will be awarded financial assistance based on selection criteria contained in the applicable application guidelines available from the department.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.7(455B) Funding sources. The department will use the funds designated by the legislature and other sources to achieve the purpose outlined in these rules.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.8(455B) Type of financial assistance. Financial assistance awarded under this program may be in the form of a loan, forgivable loan, deferred loan, grant, or a combination thereof. The type of

financial assistance offered to an applicant is dependent upon the amount of program funds awarded to each selected eligible project. The department reserves the right to offer any combination of financial assistance types to any selected eligible project.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.9(455B) Term of loans. The term of loans executed under these rules shall be determined on a case-by-case basis and shall be based on the specific costs financed, as well as the terms of other financing provided for the eligible project. The written agreement between the department and the recipient will establish other conditions or terms needed to manage or implement the eligible project.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.10(455B) Reduced award. The department reserves the right to offer financial assistance in an amount less than the amount requested by the applicant. In the event that financial assistance offered is less than the amount requested by an applicant, the applicant may be asked to document the impact of the reduced award on the proposed eligible project. Reduced awards shall be offered when the department has determined that:

1. Program resources are insufficient to provide the level of financial assistance requested to all applicants to which the department intends to offer financial assistance.
2. The applicant could implement the eligible project at a reduced level of financial assistance and achieve the eligible project objectives and purpose of this program.

[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.11(455B) Fund disbursement limitations. No funds shall be disbursed until the department has:

1. Determined the total estimated cost of the eligible project;
2. Determined that financing for the cost-share amount, if applicable, is ensured by the recipient;
3. Received confirmation that all required permits or permit amendments have been obtained by the recipient;
4. Received commitments from the recipient to implement the eligible project; and
5. Executed a written agreement with the recipient.

[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.12(455B) Applicant cost share. If requested by the department, an applicant for financial assistance shall agree to provide a cost share of funds committed to the eligible project. Financial assistance moneys received by the applicant under these rules are ineligible to be utilized for any portion of the required applicant cost share. Applicant cost share shall be in accordance with the schedule outlined in the applicable application guidelines available from the department.
[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.13(455B) Eligible costs. Applicants may request financial assistance in the implementation and operation of an eligible project which includes, but is not limited to, funds for the purpose of:

1. Purchase and installation of air pollution reduction equipment;
2. Replacement or modification of air pollution control equipment, or process and equipment, including labor for installation;
3. Development, printing and distribution of educational materials;
4. Planning and implementation of educational forums including, but not limited to, workshops;
5. Expenses directly related to implementation and operation of the eligible project; and
6. Research, laboratory analysis costs, engineering, or consulting fees.

[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.14(455B) Ineligible costs. Financial assistance shall not be provided or used for costs including, but not limited to, the following:

1. Taxes;
2. Vehicle registration;

3. Legal costs;
4. Contingency funds;
5. Proposal preparation;
6. Contractual project administration;
7. Land acquisition;
8. Office furniture, office computers, fax machines and other office furnishings and equipment;
9. Costs for which payment has been or will be received under another federal, state or private financial assistance program; and
10. Costs incurred before a written agreement between the applicant and the department has been executed. Ineligible costs shall be determined with applicable publications from the federal office of management and budget.

[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.15(455B) Written agreement. Each recipient shall enter into a contract with the department for the purposes of implementing the eligible project for which financial assistance has been awarded. The contract shall be signed by an authorized representative of the department and the authorized officer of the recipient. In cases in which the department has awarded other than a grant or forgivable loan, the recipient will be required to make regularly scheduled installment payments to retire the loan and any interest assigned to the loan as identified in the executed contract. The recipient will be required to submit periodic progress reports as identified in the executed contract. Progress reports are considered part of the public record. The department may terminate any contract and seek the return of any funds released under the contract for failure by the recipient to perform under the terms and conditions of the contract. Amendments to contracts may be adopted by mutual written consent by the department and the selected applicant.

[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

567—35.16(455B) Financial assistance denial. An applicant may be denied financial assistance for any of the following reasons:

1. Funds are insufficient to award financial assistance to all qualified applicants;
2. The applicant does not meet eligibility requirements pursuant to provisions of these rules;
3. The applicant does not provide sufficient information requested on forms provided by the department pursuant to these rules;
4. The applicant has previously received a loan under these rules and is determined by the department to be delinquent in repaying the loan;
5. The eligible project goals or scope is not consistent with these rules; or
6. The director concludes the denial is appropriate.

[**ARC 7679B**, IAB 4/8/09, effective 5/13/09; **ARC 7944B**, IAB 7/15/09, effective 8/19/09]

These rules are intended to implement Iowa Code section 455B.103(5).

[Filed Without Notice ARC 7679B, IAB 4/8/09, effective 5/13/09]
[Filed ARC 7944B (Notice ARC 7678B, IAB 4/8/09), IAB 7/15/09, effective 8/19/09]

CHAPTER 134
UNDERGROUND STORAGE TANK LICENSING AND CERTIFICATION PROGRAMS

PART A
CERTIFICATION OF GROUNDWATER PROFESSIONALS

567—134.1(455G) Definition. A "groundwater professional" is a person who provides subsurface soil contamination and groundwater consulting services, or who contracts to perform or who supervises remediation or corrective action services at leaking underground storage tank sites. A person who engages only in installation or removal of underground storage tanks and piping is not a "groundwater professional" for the purposes of this chapter.

567—134.2(455G) Certification requirements.

134.2(1) A groundwater professional must be certified as provided in 134.3(455G) before engaging in activities described in 134.1(455G), except that a person engaging in activities described in 134.1(455G) need not be certified if that person is under direct supervision of a certified groundwater professional when engaging in such activities.

134.2(2) In order to be certified as a groundwater professional, a person must be one or more of the following:

a. A person certified by the American Institute of Hydrology as a Professional Hydrologist, Professional Hydrogeologist, or Professional Hydrologist (Groundwater).

b. A person certified by the National Water Well Association or Association of Groundwater Scientists and Engineers as a Groundwater Professional.

c. A person certified by the American Board of Industrial Hygiene as an Industrial Hygienist.

d. A professional engineer registered in Iowa.

e. A professional geologist certified by a national organization (e.g., American Institute of Professional Geologists, American Association of Petroleum Geologists, Society of Independent Earth Scientists).

f. Any person with five years of direct or related experience and training as a groundwater professional or in the field of earth sciences. This must include a minimum of at least two years of education and training, and two years of experience as a groundwater professional.

g. Any person with a license, certification, or registration to practice hydrogeology or groundwater hydrology issued by any state in the United States or by a national organization, provided that the license, certification, or registration process requires, at a minimum, both of the following:

(1) Possession of a bachelor's degree from an accredited college.

(2) Five years of related professional experience.

134.2(3) In order to be certified as a groundwater professional, the applicant must complete the two-day risk-based correction action (RBCA) course and pass a certification examination offered or authorized by the department.

a. An applicant who fails an initial examination may take a second examination.

b. Failure of the second examination will result in termination of the application. A person may reapply for groundwater professional certification. The applicant must complete a regularly scheduled course of instruction before retaking the certification examination.

c. Professional engineers who qualify for an exemption from taking the certification examination under subrule 134.3(6) must attend the RBCA initial course of instruction in order to be certified.

567—134.3(455G) Certification procedure.

134.3(1) *Application.* Application for certification shall be made by completing a form provided by the department and submitting evidence of meeting the requirements found in rule 134.2(455G)(i.e., copy of certificate, license, description of experience and training).

134.3(2) *Certification fee.* The initial certification and each renewal application must be accompanied by a nonrefundable fee in the form of a check or money order payable to the Department of Natural Resources. The certification fee is $200 every two years and must be renewed biennially by

January 1 of each even-numbered year (i.e., 1994, 1996, etc.). No proration of certification fees will be done. The department will assess a fee for each training course and examination, based upon the cost of preparation and administration.

134.3(3) Rescinded IAB 1/9/02, effective February 13, 2002.

134.3(4) *Certification issuance and renewal.*

a. Upon receipt, review and acceptance of the application and certificate fee, the department shall furnish the applicant with a certificate showing the name of the individual and the expiration date.

b. In order to remain valid, a groundwater professional certificate must be renewed prior to the expiration date specified on the certificate. Renewal applications must be made on a form provided by the department and must be received by the department or postmarked at least 60 days prior to the expiration date of the registration or certification then in effect. The renewal application must be accompanied by the registration or certification fee specified in subrule 134.3(2) and proof of completing the continuing education requirements in 134.3(5).

134.3(5) *Continuing education.* All groundwater professionals are required to complete at least 12 hours of continuing education during each two-year certification period.

a. The initial course of instruction required in subrule 134.2(3) may be applied toward the first certification period's continuing education requirements. Continuing education credits may not be carried forward to the next certification period.

b. Continuing education must be in the areas relating to underground storage tank contamination assessment and corrective action activities. Courses other than those provided by the department must be submitted to the department for prior approval as meeting the continuing education requirement.

134.3(6) *Exemption from examination.* The department may provide for an exemption from the certification examination requirements for a professional engineer registered pursuant to Iowa Code chapter 542B upon submission of sufficient proof of exemption to the Iowa comprehensive petroleum underground storage tank fund board as provided in Iowa Code section 455G.18(8). The person must be qualified in the field of geotechnical, hydrological, environmental, groundwater, or hydrogeological engineering. A groundwater professional exempted under this provision must meet the continuing education requirements of subrule 134.3(5).

567—134.4(455G) Suspension, revocation and denial of certification.

134.4(1) *General policy.* It is the policy of the department to enforce standards of professional and ethical conduct which are generally accepted within the professions which qualify persons for certification in Iowa as groundwater professionals. The department intends to rely on written standards of professional and ethical conduct and competency which are applicable to persons who qualify for certification by virtue of certification by or membership in a professional organization or state licensure as provided in Iowa Code section 455G.18(2).

It is the policy of the department to investigate and enforce standards of conduct by certified groundwater professionals which fall within the scope of their professional relationships with the department, their clients and other state regulatory agencies including the Iowa comprehensive petroleum underground storage tank fund board and their agents.

134.4(2) *Lack of qualification.* The department may suspend, revoke or deny certification as a groundwater professional for any of the following reasons:

a. A material misstatement of fact in an application for certification.

b. Failure to provide the fee for certification.

c. Loss of license, certification, or registration necessary to meet the certification requirements in subrule 134.2(2).

d. Insufficient proof of qualifications required under rule 134.2(455G).

e. Failure to successfully complete the certification requirements.

f. Receipt of a "certificate of noncompliance" with a child support obligation and failure to provide a "withdrawal of a certificate of noncompliance" from the child support recovery unit as provided in Iowa Code chapter 252J.

g. Default on an obligation owed to or collected by the state as provided in Iowa Code section 421.17(34)*"e."*

134.4(3) *Discipline based on a single act or omission.* The department may suspend, revoke or deny certification based on substantial evidence of a single act or failure to act. The severity of the sanction may be based on the gravity of the act or omission and on the degree of culpability such as whether it was negligent, knowing, willful, or with such a degree of reckless disregard as to equate with intentional conduct. Single acts or omissions that may be grounds for discipline include, but are not limited to, the following:

a. Fraudulent omissions or misstatements of material fact in any reports, correspondence or communications with the department.

b. Violation of an ethical standard which the person knew or should have known and which results in or reasonably could have resulted in material consequences.

c. Failure to report the presence of contamination to the parties reasonably believed to be responsible for reporting the contamination to the department as provided in 567—Chapter 131 and 567—135.6(455B).

d. Knowingly making a material false statement, representation or certification on any application, record, report, or document required to be maintained or submitted by department rule or which is voluntarily submitted to the department.

e. Gross incompetence in the performance of groundwater professional services and corrective action.

f. Material misstatement of facts or misrepresentation of information required to be provided pursuant to Iowa Code chapters 455G and 455B, division IV, part 8.

134.4(4) *Discipline based on repeated acts or omissions.* The department may suspend, revoke or deny certification, based on substantial evidence of repeated acts or omissions which, when taken together indicate a lack of competency, professionalism, ethical conduct, or adherence to standards of performance generally expected by the profession. The severity of the sanction may be based on the gravity of the acts or omissions and the degree of culpability. Disciplinary sanctions under this subrule will not be applied without providing the person with at least one written notice of the deficiency and a written warning that future repetition may result in discipline. Conduct or omissions which may be a basis for discipline include but are not limited to the following:

a. Repeated incidents of substandard field investigation may result in suspension or revocation.

b. Repeated incidents of substandard, inaccurate or incomplete site cleanup reports and failure to follow site cleanup report instructions may result in suspension or revocation.

c. Conduct warranting a sanction after prior suspension shall result in a more severe sanction.

134.4(5) *Disciplinary procedure.*

a. Prior to issuance of a final department action imposing a disciplinary sanction of suspension, revocation or denial of certification, the department shall conduct such lawful investigation as it deems necessary to substantiate material facts sufficient to warrant a disciplinary sanction. The decision to impose a disciplinary sanction shall be made by the administrator of the environmental protection division.

b. Written notice of a sanction shall be sent by restricted certified mail to the person against whom the sanction is imposed. The notice shall provide a brief explanation of the facts relied upon and the sanction to be imposed. The notice shall inform the recipient of applicable appeal rights.

c. A person may appeal a decision imposing a suspension, revocation or denial of certification within 30 days of receipt of the notice. Upon timely receipt of the notice of appeal, contested case procedures, including informal settlement, shall apply as provided in 561—Chapter 7. In accordance with 561—subrule 7.5(2), the department shall initiate pleading by the filing of a petition.

d. Notwithstanding 561—subrule 7.15(7), the sanction imposed shall not take effect until after a contested case hearing and issuance of a proposed decision. If a timely appeal has not been filed, the sanction is effective after 30 days from receipt of the notice. A party may request stay of the sanction, as provided in 561—subrule 7.15(7), after issuance of a proposed decision.

134.4(6) *Noncompliance with support order procedures.* Upon receipt of a certification of noncompliance with a 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 a notice by restricted certified mail to the person of its intent to deny or suspend groundwater professional certification based on receipt of a certification 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.

567—134.5(455G) Penalty. A groundwater professional who fails to obtain certification with the department of natural resources as required in this chapter is subject to a civil penalty of $50. A groundwater professional who knowingly or intentionally makes a false statement or misrepresentation which results in a mistaken classification of a site shall be guilty of a serious misdemeanor and shall have the groundwater professional certification revoked.

These rules are intended to implement Iowa Code section 455G.18.

PART B
CERTIFICATION OF UST COMPLIANCE INSPECTORS

567—134.6(455B) Definition.

"UST compliance inspector" means a person who inspects a regulated underground storage tank (UST) to satisfy the requirements of 567—135.20(455B) for compliance with UST technical standards in 567—Chapter 135.

567—134.7(455B) Certification requirements for UST compliance inspectors. A person retained by an owner or operator of an UST facility for the purpose of establishing compliance with the annual UST compliance inspection required by the department under 567—135.20(455B) must hold a current UST compliance inspector certification issued by the department. Inspector certification will be issued by the department only to a person who:

1. Is an Iowa-licensed UST installer or installation inspector under 591—Chapter 15, except that the requirement as set forth under 591—subrule 15.3(4) shall not be applicable to a certified UST compliance inspector.
2. Attends the required training approved by the department as provided in 567—134.10(455B).
3. Achieves a passing grade of 85 percent on a certification examination administered or approved by the department as provided in 567—134.10(455B).
4. Submits an accurate and complete application.
5. Is not found to be in violation of this chapter and has not had a certification revoked by the department pursuant to 567—134.16(455B) or by the underground storage tank fund board pursuant to 591—Chapter 15.

567—134.8(455B) Temporary certification.

134.8(1) Until training and testing procedures are developed, the department may issue a temporary inspector certification to any person who:

a. Is an Iowa-licensed installer or installation inspector as provided in 567—134.7(455B), numbered paragraph "1."

b. Completes the U.S. EPA UST Web-based training modules: "Introduction to the Underground Storage Tanks (UST) Program" and "Basic UST Inspector Training" with a minimum passing grade of 85 percent.

134.8(2) A person issued a temporary UST compliance inspector certification must complete the approved training and pass the examination in accordance with 567—134.10(455B) by April 1, 2007.

Failure to achieve a passing grade on the examination before April 1, 2007, will result in revocation of temporary certification.

567—134.9(455B) Application for inspector certification.

134.9(1) The applicant shall be an individual.

134.9(2) An applicant for inspector certification shall submit, in addition to all applicable fees, an application on forms provided by the department. The application shall contain the following information:

a. Evidence that the applicant meets the experience and qualification prerequisites contained in 567—134.7(455B).

b. The applicant's name, address and telephone number.

c. Other information necessary for a determination of the applicant's qualifications.

134.9(3) Training and certification fees. An initial nonrefundable application fee of $150 in the form of a check or money order payable to the Department of Natural Resources must accompany the initial application for certification and $50 for each renewal application. The $150 application fee covers the cost of the certification examination. The department will assess an additional fee for each training course based upon the cost of administration.

134.9(4) An application for certification must be received by the department no later than 60 days prior to the announced date of the certification examination.

134.9(5) An application must be complete upon submission.

134.9(6) An applicant meeting the requirements of this rule will be granted admission to the examination for inspector certification.

567—134.10(455B) Training and certification examination.

134.10(1) Prior to taking the compliance inspector examination, the applicant must:

a. Complete the U.S. EPA UST Web-based training modules: "Introduction to the Underground Storage Tanks (UST) Program" and "Basic UST Inspector Training" with a minimum passing grade of 85 percent.

b. Attend the department's inspector training course or designated approved course.

134.10(2) The department will establish administrative and technical content for the examination and the standards and criteria against which the department will evaluate candidates in determining the fitness of candidates for inspector certification.

134.10(3) At least once in each calendar year, the department will schedule a date and location for the examination for certification of inspectors.

134.10(4) Only applicants who have been authorized by the department to take an examination will be admitted to an examination or issued a certification as a result of passing an examination. Authorization to take an examination will be based on the applicant's compliance with the requirements of this chapter.

134.10(5) To receive a passing grade on the examination, the applicant for certification must achieve a minimum score of 85 percent. An applicant who fails an initial examination may take a second examination.

134.10(6) The application of an applicant who fails the second examination will be terminated. An applicant who fails the second examination may reapply for inspector certification but may not retake the examination until the applicant has successfully completed a regularly scheduled course of instruction that is administered or approved by the department. Successful completion means attendance at all sessions of training and attainment of the minimum passing grade established by the department for the approved training course.

567—134.11(455B) Renewal of certification.

134.11(1) *Renewal period.* Certification shall be for a two-year period and must be renewed by January 1 of each odd-numbered year, beginning January 1, 2009. Applications for renewal must be submitted on a form provided by the department and no later than 60 days prior to the expiration date. If

a certified inspector fails to renew the certification by the expiration date, the department may grant, upon a showing of good cause, a 30-day grace period during which the applicant may submit the application and payment of the renewal fee as provided in 134.9(3).

134.11(2) *Continuing education.* Certified inspectors must successfully complete eight hours of training approved by the department to maintain certification.

134.11(3) *Minimum inspections.* In order to renew certification, an inspector must have conducted at least 25 compliance inspections each year.

567—134.12(455B) Professional liability insurance requirements. All certified compliance inspectors are required to have professional liability insurance with minimum liability limits of $1 million per occurrence and in the aggregate. All persons covered by the certification provisions of this chapter shall provide written proof of coverage upon request of the department.

567—134.13(455B) Licensed company. A company employing certified UST compliance inspectors shall be registered with the department as a licensed UST compliance company. A company shall lose its license if it fails to employ at least one certified inspector or if it employs uncertified individuals to do compliance inspections required by the department. The annual license fee is $50.

567—134.14(455B) Compliance inspection. The UST compliance inspector shall conduct a compliance inspection in accordance with the standards set out in this rule and with department written instructions and guidelines. The inspector shall notify the department of the date of a site inspection at least ten days prior to the inspection or another time frame approved by the department.

134.14(1) Inspection process. The inspector shall record the inspection on a form provided by the department and conduct the inspection to address all items contained on the inspection form. The department may approve an alternative inspection form if requested by the inspector. The completed inspection form must be maintained by the inspector or licensed company for five years. Upon completion of the site inspection, the inspector shall send an inspection report to the owner and operator within ten business days, except for the notice of a potential suspected or confirmed release as provided in paragraph *"b."* At a minimum, the report shall satisfy the following:

a. The inspector shall notify the owner and operator of any compliance violations or deficiencies and those specific actions necessary to correct the violations or deficiencies in accordance with 567—Chapter 135.

b. The inspector shall immediately upon discovery notify the owner and operator of a suspected release as provided in 567—135.6(455B). The notice shall advise the owner and operator of their duty to report the condition to the department within 24 hours or within 6 hours if a hazardous condition exists as defined in 567—131.1(455B) and of their duty to take necessary steps to investigate and confirm suspected releases within the time frames specified in 567—135.6(455B). The inspector shall record in the inspection report submitted to the department the date and time of the notice to the owner and operator.

c. The inspector shall notify the owner and operator of applicable time frames to correct violations or deficiencies if established by rule, or within 60 days of receipt of the inspection report or another reasonable time period approved by the department.

d. The inspector may enter the initial site inspection results electronically as provided in 134.14(2) and complete a follow-up final electronic report as provided below or wait until completion of the follow-up activities to submit a final electronic report. In either case, a final electronic report shall be submitted to the department and a copy provided to the owner and operator as provided in 134.14(2), within the following time frames:

(1) Within 10 business days of the inspection, if the results of the inspection find no violations or deficiencies requiring corrective action.

(2) Within 10 business days of the inspector's receipt of all necessary documentation of all action required to correct violations and deficiencies.

(3) In any case, no later than 90 days of the site inspection.

134.14(2) Electronic inspection reporting. The inspector shall prepare an electronic report in accordance with the following:

a. The inspector shall enter the results of the site inspection discovered at the time of the inspection and any actions taken to correct violations and deficiencies on an Internet-based electronic format developed by the department and in accordance with guidance. The department's software will be capable of generating an inspection report.

b. The department will develop a generally compatible electronic platform using XML language. The department will provide the XML schema file format to describe the data needed to allow an inspector to transfer multiple site inspection results in an electronic batch process over the Internet using the department's inspection Web site.

c. The inspector shall provide a print copy of the electronically generated inspection report to the owner and operator or an alternative report approved by the department.

134.14(3) Any evidence of violations or deficiencies observed during the inspection must be photographed using a digital camera with at least a 1-2 megapixel resolution. The digital photographs must be submitted as part of the electronic inspection report and maintained by the inspector for five years as part of the inspector's records.

134.14(4) The inspector must provide any inspection records provided by the owner and operator to the department upon request.

134.14(5) Inspection technical requirements. An inspector of an UST system must check for compliance with the technical standards of 567—Chapter 135 following the department's guidance. The inspection of an UST system currently in operation shall include, but not be limited to, the following:

a. The material currently stored in the UST.

b. The type of tank and lines currently at the site as compared to the registered information on the department's database.

c. Checking site records demonstrating operational compliance, 567—subrule 135.4(5).

d. Checking release detection records, 567—subrule 135.5(6).

e. Visually checking for releases or other violations by opening covers of dispensers, manways, and containment sumps for submersible pumps and other piping connections for:

(1) Indications of a product release and leaking equipment.

(2) Deteriorating product lines or excessive bends in product lines or flex connectors.

(3) Proper anchoring of breakaways (dispensers only).

f. Current operating status of cathodic protection system, if present.

g. Presence and operational condition of spill and overfill equipment, 567—paragraph 135.3(1)*"c."*

Any problems observed during the inspection must be photographed using a digital camera with at least a 1-2 megapixel resolution.

567—134.15(455B) Disciplinary actions.

134.15(1) The department may impose disciplinary actions which may include, but are not limited to, notices of deficiency, probationary notices, suspension of a certification or license and, pursuant to 567—134.16(455B), revocation of a certification or license.

134.15(2) A notice of deficiency or probationary notice shall not be an appealable decision. The recipient of a notice may contest the basis for the notice in writing, and such response shall be made part of the certification record. A person subject to a notice to suspend or revoke a certification may appeal the notice as provided in 567—Chapter 7.

134.15(3) The department may suspend the certification of a certified inspector or licensed company for good cause, and based on a single act or omission or repeated acts or omissions. The suspension may require the certified inspector to take remedial measures intended to correct or prevent future acts and omissions. Good cause includes, but is not limited to:

a. A violation of these rules.

b. Negligent misrepresentation of material facts in a compliance report.

c. Negligent failure to identify a material violation of UST operation and maintenance standards set out in 567—134.14(455B).

d. Repeated failure to conduct compliance inspections and submit reports in accordance with the standards set out in 567—134.14(455B).

e. Incompetence on the part of the certified inspector as evidenced by errors in the performance of duties and activities for which the certification was issued.

f. Repeated failure to submit reports of inspection activities to the department or the owner and operator as provided in 567—134.14(455B).

134.15(4) The suspension of a company license or inspector certification shall prevent the company or person from engaging in activities for which certification or licensure is required.

134.15(5) The department may require that the certified inspector successfully complete a special training program, examination or other remedial measures sponsored or approved by the department and designed to strengthen the specific weakness in the certified inspector's performance of duties as identified in the suspension order.

134.15(6) A certified inspector or licensed company shall immediately surrender the certificate or license, as applicable, to the department as of the effective date of a suspension order. The department may reinstate the certification or license if it is determined the person has satisfied the terms of the suspension order and the certification has not expired.

567—134.16(455B) Revocation of inspector certification or company license.

134.16(1) The department may revoke the inspector certification or company license for one or more of the following:

a. Willful disregard of, or willful or repeated violations of, this chapter or 567—Chapter 135.

b. Fraudulent omissions or misstatements of material facts in a compliance inspection report or in other written or oral communications with the department.

c. A knowing and willful failure to detect and report a material violation of UST operation and maintenance standards as part of a compliance inspection required by 567—135.20(455B).

d. Acts or omissions warranting suspension after having certification or license previously suspended.

e. The revocation of a certification as an installer or installation inspector under 591—Chapter 15.

134.16(2) A certified inspector or licensed company shall immediately surrender certification or licensing documents after the effective date of a revocation decision.

These rules are intended to implement Iowa Code section 455B.474.

PART C
LICENSING OF UST PROFESSIONALS

567—134.17(455B) Definitions. As used herein:

"Board" means the Iowa comprehensive petroleum underground storage tank fund board.

"Cathodic protection tester" means a licensed individual who provides installation, maintenance and testing services on underground storage tank corrosion protection systems.

"Certificate of noncompliance" means a document provided by the child support recovery unit certifying that the named obligor is not in compliance with a support order or with a written agreement for payment of support entered into by the unit and the obligor.

"Child support recovery unit" means the child support recovery unit created by Iowa Code section 252B.2.

"Deductible" means the portion of a claim paid by insureds on the policy issued by the board.

"Department" means the Iowa department of natural resources.

"Install" or *"installation"* means the physical construction of a UST system including, but not limited to, activities such as excavating, backfilling, testing, placement of the tank, underground piping, release detection devices, corrosion protection systems, spill and overfill devices and any associated administrative activities such as notifications, record keeping and record submissions.

"Installation inspector" means a licensed individual who is engaged in the inspection and approval of the installation of new or upgraded underground storage tank systems.

"Installer" means a licensed individual or licensed company engaged in the installation of a new underground storage tank system or the upgrading of underground storage tank systems.

"In the aggregate" means for all claims or suits in a single year seeking damages under an insurance policy issued by the board.

"Licensed company" means a person, or company which employs a person who meets all of the qualifications to install, upgrade, repair, test or line underground storage tank systems.

"Licensed individual" means an individual who has received a license to perform any of the activities regulated under this chapter.

"Liner" means a licensed company or an individual who provides services to install underground storage tank lining and to repair underground storage tanks.

"Maintenance" means the normal operational upkeep to prevent a UST system from releasing a regulated substance or to ensure that a release is detected.

"Modification" means to change a UST system currently in use by the installation of new UST system components. "Modification" includes, but is not limited to, the addition of corrosion protection to a previously lined tank, installation of new underground piping or replacement of existing underground piping, changing the primary release detection method to one of the methods listed in OAR 340-150-0450 through 340-150-0470, or adding secondary containment. "Modification" does not include those activities defined in this rule as "repair" or "replacement."

"Obligor" means a natural person as defined in Iowa Code section 252B.1 who has been ordered by a court or administrative agency to pay support.

"OSHA" means the Occupational Safety and Health Act.

"Precision test" means a tank and line tightness test that meets the requirements in rule 567—135.4(455B).

"Removal" means the process of removing and disposing of an underground storage tank system no longer in service or the process of abandoning an underground storage tank system in place, in accordance with rule 567—135.9(455B).

"Remover" means a licensed individual who is engaged in permanent closure activities by removal or filling in place of underground storage tank systems in accordance with rule 567—135.15(455B).

"Repair" means to restore any portion of a UST system that has failed. "Repair" does not include the activities defined in this rule by "modification" or "replacement."

"Replacement" means to effect a change in any part of a UST system above grade by exchanging one unit for a like or similar unit. "Replacement" does not include activities defined in this rule as "repair" or "modification."

"Self-insured retention" means the portion of a claim paid by insureds who self-insure a portion of their risk as part of a policy issued by the board. Expenses included as a part of the self-insured retention are the cost of claims settlements or suits, the cost of adjusting, legal fees, court costs and any other investigative cost associated with the claim.

"Service technician" means a nonlicensed individual who works for a licensed individual or a licensed company or who is certified by a manufacturer to conduct modification or replacement activities at UST facilities.

"Tester" means a licensed company or individual who tests tanks, lines, leak detection systems, or monitoring systems as required by 567—Chapter 135 and this chapter. For the purposes of this definition, an owner, operator or an employee of an owner or operator performing leak detection or cathodic protection monitoring, as required by 567—Chapter 135, is not a tester.

"Testing" means the process of utilizing a system to test underground storage tank systems or any part thereof for tightness, leak detection, cathodic protection or monitoring.

"Underground storage tank professional" means an individual licensed under Part C of this chapter.

"Underground storage tank system" means tank or tanks and associated piping intended to contain and dispense petroleum products and for which proof of financial responsibility is, or on a date definite will be required to be maintained pursuant to the Federal Resource Conservation and Recovery Act, 40

CFR 280, and the regulations in effect on December 31, 1994, adopted pursuant to that Act or successor Acts or amendments.

"Unit" means the child support recovery unit created in Iowa Code section 252B.2.

"U.S. EPA" means the United States Environmental Protection Agency.

"Withdrawal of a certificate of noncompliance" means a document provided by the unit certifying that the certificate of noncompliance is withdrawn and that the licensing authority may proceed with issuance, reinstatement, or renewal of an obligor's license.

[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.18(455B) Applicability of Part C. All persons and companies that are currently licensed under the former board rules in rescinded 591—Chapter 15 shall be subject to Part C of this chapter. All persons conducting underground storage tank installations and installation inspections as provided in 567—subparagraph 135.3(1)*"e"*(2) and installers, installation inspectors, liners, testers, and removers shall be licensed by the department in accordance with Part C of this chapter. Service technicians as defined in rule 567—134.17(455B) are exempt from licensure under Part C of this chapter.

[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.19(455B) General licensing requirements. Applications for licenses shall be submitted on a form provided by the department along with all required supporting documentation. Existing licenses as of [insert the effective date of these amendments] and new licenses shall expire December 31, 2010. Subsequently, licenses shall be issued and renewed on a two-year calendar basis, beginning January 1, 2011. All applicants must be at least 18 years of age. The applicant shall not have been issued a certificate of noncompliance from the child support recovery unit.

134.19(1) *Licensing classifications.* A separate license will be issued for:

a. UST installers and installation inspectors;

b. UST removers;

c. UST testers;

d. Cathodic protection testers; and

e. UST liners.

134.19(2) *Individual and company licenses.* A company employing licensed individuals for installation, upgrading, removal, lining or testing of underground storage tank systems shall be registered as a licensed company. A company shall have its license revoked if it fails to employ at least one licensed individual or if it employs unlicensed individuals to do work requiring a license. Individuals who are not companies as defined in rule 567—134.17(455B) are required to have an individual license only.

134.19(3) *License fees.* A $200 fee shall be submitted with a company license application and with an individual license application. Companies and individuals are licensed separately as set forth in subrule 134.19(2). Individuals may apply for multiple individual licenses at once, paying only one $200 processing fee. All fees are nonrefundable.

134.19(4) *License issuance.* Upon receipt, review, and acceptance of the application and application fee, the department shall furnish the applicant with a license showing the name of the individual/company and the expiration date. In order to remain valid, the license shall be renewed prior to the expiration date specified on the license.

134.19(5) *Environmental liability insurance.* All license holders, including licensed companies, are required to have environmental liability insurance with minimum liability of $1 million per occurrence, as well as in the aggregate. Current license holders shall have 45 days from August 19, 2009, to upgrade their environmental liability insurance.

a. Licensed company. A licensed company is required to provide environmental liability insurance for all licensed activities of the company and its licensed UST professionals.

b. Licensed individuals. Each licensed installer, installation inspector, remover, liner, cathodic protection tester, and tester is required to provide proof of environmental liability insurance covering licensed activities. The insurance may be provided by the licensed company employing the licensed individual or by the individual licensee.

c. Insurance exception. UST professionals employed by owners or operators of underground storage tank systems to work only on the owner's or operator's private system(s) are exempt from insurance requirements.

d. Forms of acceptable insurance. All parties covered by the licensing provisions of Part C of this chapter shall provide evidence of environmental liability insurance to the department upon request.

(1) Environmental liability insurance may be provided by a private insurer authorized to do business in Iowa.

(2) Evidence of environmental liability insurance may be provided using methods of self-insurance as outlined in 567—Chapter 136.

134.19(6) *Examinations and course of instruction.* Prior to the issuance of a license as an installer, installation inspector, remover, liner, tester, or cathodic protection tester, the applicant shall successfully complete a department or department-approved course of instruction and pass a qualification examination approved by the department.

a. Examination requirements for all license holders.

(1) A passing grade of not less than 85 percent is required on the Iowa examination.

(2) Candidates who have failed the examination may not perform work unless supervised by an appropriately licensed individual.

(3) A fee reflecting the actual costs of developing and administering each course of instruction and examination shall be charged.

(4) Nothing in Part C of this chapter shall limit the right of the department to require additional educational requirements of license holders.

b. Exceptions to completion of the course of instruction or examination. All license holders, except cathodic protection testers, are required to complete the course of instruction. Cathodic protection testers are only required to maintain NACE certification, STI cathodic protection certification or equivalent certification approved by the department. Testers may qualify for reciprocity under paragraph 134.19(6)*"c"* if the department approves the public or private certification or training program completed. For testers, the department will approve or deny the certification based upon a review of the course of instruction, applicable manuals and handouts, and the examination.

c. Reciprocity. Persons who are certified under another state or federal regulatory program which has been approved by the department may be eligible for licensure in Iowa without having to take a course of instruction or pass the examination. However, these individuals shall still pay the $200 application fee and qualify for license renewal by fulfilling continuing education requirements.

d. Repeat examination attempts. An applicant who fails an initial examination may take a second examination within one calendar year without having to retake the course of instruction. Failure of the second examination will result in termination of the application. A person may reapply for licensure. The applicant shall complete a course of instruction before retaking the examination.

134.19(7) *Continuing education.* Each person licensed under Part C of this chapter shall complete a department-approved refresher course every two years, except for licensed cathodic protection testers. Cathodic protection testers shall maintain NACE or STI certification or another certification approved by the department. Beginning with the first application for license renewal, each UST professional shall provide evidence to the department, prior to submission of the application for renewal, that at least 12 credit hours of department-approved continuing education have been satisfactorily completed since the last license was issued or renewed. The department may limit the number of credits granted for similar courses during a renewal period. The requirement for continuing education may be met only by those continuing education offerings which have been approved by the department.

a. Form of approval. Approval may take the form of:

(1) Program approval granted by the department to the sponsor or instructor of a continuing education offering;

(2) Individual requests for credit granted by the department to an installer or inspector for a continuing education offering whose sponsor or instructor did not seek program approval; or

(3) Blanket approval granted by the department to continuing education offerings sponsored by the department or other professional organizations whose standards have been approved by the department.

b. Procedures for department approval of continuing education offerings.

(1) Application for program approval shall be made by the sponsor or instructor to the department and include an agenda or an outline of the content of the proposed continuing education offering.

(2) Application shall be made at least 45 days prior to the desired effective date of approval.

(3) The application shall be reviewed by the department, and notice of approval or denial of program approval shall be sent to the sponsor or instructor. Credit hours may be limited by the department based on program content.

c. Proof of participation. A certificate of satisfactory completion of a department-approved continuing education offering issued by the sponsor or instructor constitutes sufficient evidence of satisfactory completion for purposes of meeting the continuing education requirement.
[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.20(455B) License renewal procedures.

134.20(1) Renewal applications shall be made on a form provided by the department and received by the department or postmarked no later than November 1 of the expiration year of the license at issue. The renewal application shall be accompanied by the $200 renewal fee as specified in subrule 134.19(3) and proof of environmental liability insurance as required under subrule 134.19(5). Applications received after the November 1 deadline, but before the January 1 expiration date, will be accepted and will require an additional $50 late fee.

134.20(2) To be eligible for renewal, the licensee shall fulfill all continuing education requirements, along with any other requirements set forth in each license classification rule under Part C of this chapter. The department will consider all past disciplinary actions against the licensee when evaluating renewal eligibility.
[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.21(455B) Conflict of interest. A licensed individual or a licensed company may not conduct a UST installation inspection at any facility at which the licensee is engaged in professional services which are regulated under Part C of this chapter, e.g., installations, modifications, repairs, or replacements of UST systems. A person working for a licensed company as an installer, liner, remover, or tester shall not provide services as an installation inspector on sites where UST systems are being installed or lined by the person's prior employer until six months after leaving the prior employer's licensed company. If a licensed individual leaves the employment of a licensed company, the licensed company shall notify the department within 30 days of that occurrence.
[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.22(455B) Duty to report. Any UST professional licensed under Part C of this chapter shall timely report suspected and confirmed releases within 24 hours of discovery (6 hours if a hazardous condition exists) as described in rule 567—135.6(455B) to the owner and operator on a form prescribed by the department. The UST professional shall recommend to the owner and operator any release confirmation actions or other investigatory and response actions which in the UST professional's judgment would be consistent with the requirements of rule 567—135.6(455B). The UST professional shall submit a copy of the form to the department within seven days of discovering a confirmed release. The UST professional is not responsible for reporting a suspected release as described in rule 567—135.6(455B) directly to the department.
[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.23(455B) OSHA safety requirements. All licensed individuals and companies regulated under Part C of this chapter shall conduct their work as required by OSHA safety requirements defined under 29 CFR § 1910 (2006). OSHA standards apply whenever flammable, combustible, or hazardous materials are present, especially during the following activities:

1. Excavating, placing underground storage tank systems in excavations, and ballasting underground storage tank systems with flammable, combustible, or hazardous materials.

2. Purging, cleaning, and removal of underground storage tank systems which have contained flammable, combustible, or hazardous materials.

3. Testing as a part of an installation or after the system has been placed in service.

[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.24(455B) Installers.

134.24(1) *Licensure qualifications.* An installer of an underground storage tank system shall apply for a license as an installer and shall indicate on the license application the types of installations and upgrade procedures the installer intends to use. In addition to the licensing requirements listed under rule 567—134.19(455B), an installer must:

a. Provide documentation of at least two years of relevant experience;

b. Provide documentation of manufacturer certification for past installations and proof of current certification for future work including, but not limited to, tank systems, piping systems, leak detection and monitoring systems, and corrosion protection systems; and

c. Have completed at least 40 hours of OSHA training.

134.24(2) *Renewal qualifications.* To be eligible for license renewal, an installer shall:

a. Fulfill the department's continuing education requirements in rule 567—134.19(455B);

b. Maintain manufacturer certification if available and notify the department within 30 days if the certification is lost; and

c. Complete the annual eight-hour Hazardous Waste Operations and Emergency Response (HAZWOPER) refresher course.

134.24(3) *Responsibilities of installers.* A licensed installer shall be on site during the performance of all work, including subcontracted work, for which the owner/operator has contracted to have completed by the installer. The licensed installer is responsible for all UST-related work at the site and must ensure that the performance of the work and the finished work conform to industry standards and codes and manufacturers' requirements. The licensed installer is responsible for ensuring that all local installation permits and notice requirements are satisfied. Tank installation includes all work associated with the placement of the tanks, pipes, pumps, dispensers, gauging systems, monitoring systems, corrosion protection, containment devices, and ancillary systems which, if installed incorrectly, could cause or delay detection of a leak. Tank installation specifically includes excavation, equipment placement, backfilling, piping, electrical work, testing calibration, and start-up. Tank installation also includes installation of the appropriate equipment to meet National Emissions Standards for Hazardous Air Pollutants (NESHAP) requirements (40 CFR § 63.6580, Subpart ZZZZ), including submerged fill and vapor balance systems (Stage 1 vapor recovery) and the testing of those systems. Installers shall have on their person at all times while on a UST job site a 40-hour general site worker program identification card or any valid refresher card that complies with OSHA standards.

134.24(4) *Documentation of work performed.* Installing a new UST system or upgrading a UST system requires an installer to submit a copy of DNR Form 148, signed by the owner, to the department. Each licensed installer responsible for the new system installation or the upgrading of an existing system shall sign DNR Form 148 as required by 567—paragraph 135.3(3)*"e."*

[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.25(455B) Testers. A tester of underground storage tank systems shall apply for licensing as a tester and note on the license application the systems and method(s) of testing the tester will use. In addition to the licensing requirements listed under rule 567—134.19(455B), a tester shall provide documentation of at least two years of relevant experience, documentation of manufacturer certification for past testing, and proof of current certification for future work.

134.25(1) *Renewal qualifications.* To be eligible for license renewal, a tester shall fulfill the department's continuing education requirements in rule 567—134.19(455B) and shall maintain manufacturer certification or notify the department within 30 days if the certification is lost.

134.25(2) *Documentation of work performed.* A copy of the test results shall be attached to DNR Form 148 when testing is done in connection with a new installation or the upgrading of an existing underground storage tank system. A precision test is required when the system is covered and is ready

to be placed into service; a volumetric, nonvolumetric, or vacuum test may be used as a method for testing the system and a hydrostatic pressure test may be used for testing the lines. Systems used for leak detection or monitoring (such as statistical inventory reconciliation, vapor or water monitoring wells, or tracer-type tests) shall not be acceptable as a precision test at the completion of the installation of a new system or the upgrading of an existing system. Automatic in-tank gauging may be acceptable if third-party U.S. EPA approval as a precision test has been received for testing tanks.

a. The test results shall identify the tanks tested, the test method employed, and the results of the test. Test results shall be dated and signed by the licensed tester who performed the tests.

b. The original DNR Form 148 without attachments shall be mailed to the department.

134.25(3) *Exception to inspection requirement.* Installation inspectors are not required for the testing of underground storage tank systems, lines, leak detection, and cathodic protection as required by 567—Chapter 135 after the system has been put into service.

[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.26(455B) Liners. In addition to the licensing requirements listed under rule 134.19(455B), a liner shall provide documentation of at least two years of relevant experience, provide documentation of manufacturer certification for past linings and proof of current certification for future work, and have completed at least 40 hours of OSHA training.

134.26(1) *Renewal qualifications.* To be eligible for license renewal, a liner shall:

a. Fulfill the department's continuing education requirements in rule 567—134.19(455B);

b. Maintain manufacturer certification and immediately notify the department if the certification is lost; and

c. Complete the annual eight-hour Hazardous Waste Operations and Emergency Response (HAZWOPER) refresher course.

134.26(2) *Lining system investigation and installation requirements.*

a. Inspection of internal lining. A steel underground storage tank that satisfies the corrosion protection requirement as set forth in 567—subparagraph 135.3(2)*"b"*(1) by the addition of an internal lining shall be internally inspected within ten years of the date the tank was lined and every five years thereafter. The purpose of the inspection is to determine if the lining continues to perform according to the manufacturer's specifications, state and federal rules, and national standards and codes and to determine if the tank is still structurally sound. The department accepts both manned entry and video camera periodic inspections. The lining method employed must be specifically designed for the purpose, be compatible with the product stored, and meet acceptable federal and state standards as set forth in 567—Chapter 135.

b. Integrity testing for tanks. Liners shall verify structural integrity, to include thickness and strength of the underground storage tanks, whenever tanks are physically entered (manned entry) for periodic inspections. The following standards must be used for lining and periodic inspections and integrity testing:

(1) Physical (manned entry) inspection. American Petroleum Institute (API) Standard 1631: Interior Lining and Periodic Inspection of Underground Storage Tanks.

(2) Video camera inspection. API Standard 1631; "Recommended Practice for Inspecting Buried Lined Steel Tanks Using a Video Camera" developed by Ken Wilcox Associates Inc. (KWA), Methods A and C; and ASTM G-158 (approved prediction models).

(3) Repairs to lining. Standard 631 of the National Leak Prevention Association (NLPA): Entry, Cleaning, Interior Inspection, Repair and Lining of Underground Storage Tanks. Repaired lining must meet the requirements of API 1631 § 8.

(4) Documentation of the inspection. API 1631—Form C: Tank Re-Inspection Affidavit. Liners shall document any defects noted in the system including, but not limited to, holes and perforations using API 1631—Form C: Tank Re-Inspection Affidavit and shall include photographs of all methods of repair.

134.26(3) *Responsibilities of liners.* While on UST job sites, liners shall have on their person at all times a 40-hour general site worker program identification card or any valid refresher card that complies with OSHA standards.

134.26(4) *Documentation of work performed.* A liner shall submit the API 1631 report form to the department, certifying that all work was performed in accordance with applicable industry standards.
[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.27(455B) Installation inspectors. In addition to the licensing requirements listed under rule 134.19(455B), an installation inspector shall provide documentation of at least one year of experience with underground storage installations, testing, inspecting, or design; documentation of manufacturer certification for past work; and proof of current certification for future work. An engineer who intends to apply for licensure as an installation inspector and who has met the requirements in Iowa to be a registered professional engineer (P.E.) may be exempt from the educational requirement so long as UST installation is in the scope of the engineer's P.E. license and regular practice as provided for in rule 567—134.19(455B). Engineers, however, are not exempt from fulfilling the examination requirement.

134.27(1) *Renewal qualifications.* To be eligible for license renewal, an installation inspector shall fulfill the department's continuing education requirements in rule 567—134.19(455B) and shall maintain manufacturer certification or notify the department within 30 days if the certification is lost.

134.27(2) *Documentation of work performed.*

a. A copy of the inspection report must be submitted within 14 days after the inspection is complete. Both the inspection form and DNR Form 148 must be received by the department before the UST system can be activated.

b. A licensed installation inspector shall inspect the job site a minimum of three times during the course of the new tank installation or system upgrade.

c. For new installations, the first inspection shall occur before the UST system is installed. The second inspection shall occur before the covering of the system, when all tanks and pipes are exposed. The inspector shall witness testing of the primary and secondary piping and testing of the secondary containment, including sumps, under-dispenser containment (UDC), and secondary containment leak detection equipment. The final inspection shall occur when all components are operational and the system has been covered, but before actual operation. The installation inspector shall be present on site, shall visually observe all inspections, and shall be able to attest to the results. A video or other recording device showing the work completed by the installer shall not be used nor shall it be an acceptable method of providing independent inspection of the work completed.

134.27(3) *Inspection required.* When concrete is cut or excavation is required that could affect the integrity or operation of the UST system or when a component that routinely contains product is installed, replaced or repaired, one inspection is required. This inspection shall occur when the component is uncovered and replaced or repaired but before operation recommences. Whenever secondary containment, such as UDC or sump, is installed, at least one inspection is required after the equipment is installed and before the sytem is backfilled.

134.27(4) *Inspection not required.* Replacing, repairing or installing the following does not require an inspection: drop tubes, overfill devices, spill buckets, installation of ATG systems, dispensers, submersible turbine pumps, automatic line leak detectors, internal lining and periodic inspections or lining repair, cathodic protection systems, interstitial sensors, flex connectors, and line and tank tightness testing.

134.27(5) *Pre-work notification requirement.*

a. A licensed company/individual hired by an owner/operator to perform work shall notify the owner's/operator's licensed installation inspector of choice prior to commencing work. Additionally, the owner/operator is responsible for supplying the name of the installation inspector if it is not a governmental entity to any state or local agency with rules affecting installations or upgrades.

b. The pre-work notice given to the installation inspector shall include, at a minimum, the following information:

(1) Description of the work planned.
(2) The licensed individual responsible for the work to be performed.
(3) A schedule of the work to be performed.
(4) A copy of the UST notification of intent to install form submitted to the department.

c. The installation inspector shall review the work plan, and any required changes by the installation inspector must be submitted to the company/individual prior to the beginning of the described work. An inspection schedule must be agreed upon before work commences. Changes to the work schedule, to include the inspection schedule, because of weather or unforeseen job-site conditions shall be agreed upon as soon as the extenuating circumstances are recognized.

134.27(6) *Pre-installation and installation checklists.*

a. The licensed company/individual performing the work shall submit to both the installation inspector and the department a notification of intent to install form 30 days prior to an installation or upgrade.

b. Installation inspectors are required to use the department's installation inspection checklist. The installation inspection checklist must be submitted within 14 days following the tank installation inspection.

134.27(7) *Conflict of interest.* In addition to the conflict-of-interest provisions outlined in rule 567—134.21(455B), the following apply to installation inspectors:

a. If the installation inspector establishes a contract to perform inspection services for an owner/operator, or performs more than five inspections per calendar year for any one owner/operator, then the installation inspector is required to disclose that relationship in writing to the department within 30 days of the fifth inspection.

b. The department may require the owner/operator to seek alternative inspection services for any reason deemed prudent to ensure quality installations.

134.27(8) *Miscellaneous requirements.* An installation inspector has the right to postpone work or to stop work on a job if standards as outlined in Part C of this chapter are not followed by the installer. Furthermore, once an installation inspector has been placed on a job, that installation inspector cannot be replaced without the department's approval. Installation inspectors must verify that any local permit and notice requirements are in place.

[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.28(455B) Removers. In addition to the licensing requirements listed under rule 567—134.19(455B), a remover shall provide documentation of at least two years of removal or other relevant experience and complete at least 40 hours of OSHA training. An engineer who intends to apply for licensure as a remover and who has met the requirements in Iowa to be a registered professional engineer (P.E.) may be exempt from the licensure requirements under rule 134.19(455B) so long as UST-related work is within the scope of the engineer's P.E. license and regular practice. Engineers are not exempt from fulfilling the examination requirement in subrule 134.19(6).

134.28(1) *Renewal qualifications.* To be eligible for license renewal, a remover shall:

a. Fulfill the department's continuing education requirements in rule 567—134.19(455B);

b. Comply with all local permitting and notice requirements;

c. Comply with department-issued UST closure guidance; and

d. Complete the annual eight-hour Hazardous Waste Operations and Emergency Response (HAZWOPER) refresher course.

134.28(2) *Responsibilities and documentation of work performed.* A licensed remover shall be on site during the performance of all UST closure-related work, including subcontracted work, for which the owner/operator has contracted to have completed by the remover. Removers are responsible for ensuring that all work performed complies with the safety requirements of OSHA. Removers shall submit to the department a notification of closure form 30 days prior to the scheduled removal or fill in place as required in 567—subrule 135.15(2). Removers shall submit to the department the closure report within 45 days of removal or fill in place as required in 567—paragraph 135.15(3)*"e."* Removers shall ensure that all local permits and notice requirements are satisfied. Removers shall have on their person at all times while on a UST job site a 40-hour general site worker program identification card or any valid refresher card that complies with OSHA standards. The closure investigation required by 567—subrule 135.15(3) may be conducted by a licensed remover if the remover is a certified groundwater professional licensed

under Part A of this chapter. If the remover is not a certified groundwater professional, the remover may subcontract with a certified groundwater professional.
[**ARC 7946B**, IAB 7/15/09, effective 8/19/09]

567—134.29(455B) Disciplinary actions.

134.29(1) *General policy.* It is the policy of the department to enforce standards of professional and ethical conduct which are generally accepted within the professions which qualify a person for licensure in Iowa under Part C of this chapter. The department intends to investigate and enforce standards of conduct by a licensee which fall within the scope of the licensee's professional relationship with the department, the licensee's clients, and other state regulatory agencies. The department may impose disciplinary actions which may include, but are not limited to, notice of deficiency; probationary notices; and suspension, revocation, and denial of a license. The criteria identified in subrules 134.20(1) and 134.20(2) will be utilized by the department in deciding whether to issue an initial license or to renew a previously issued license.

134.29(2) *Notice of deficiency or probation.* A notice of deficiency or probationary notice shall not be an appealable decision. The recipient of a notice may contest the basis for the notice in writing, and such response shall be made part of the licensee's record. A person subject to a notice to suspend or revoke a license may appeal the notice as provided in 567—Chapter 7.

134.29(3) *Suspension.*

a. The department may suspend the license of any individual or company for good cause for either a single act or omission or repeated acts or omissions. The suspension of a company or individual licensee shall prevent the company or individual licensee from engaging in activities for which the license is required. The suspension may require the licensee to take remedial measures intended to correct or prevent future acts or omissions. Good cause includes, but is not limited to:

(1) A violation of these rules.

(2) Negligent misrepresentation of material facts in a report submitted to the department.

(3) Incompetence on the part of the licensee as evidenced by errors in the performance of duties and activities for which the license was issued.

(4) Repeated failure to submit reports of activities to the department or the owner/operator as provided in this chapter.

b. The department may require that the licensee complete a special training program, examination, or other remedial measures sponsored or approved by the department and designed to strengthen the specific weakness in the licensee's performance of duties as identified in the suspension order.

c. A licensed company or individual shall immediately surrender the applicable license to the department as of the effective date of a suspension order. The department may reinstate the license if it is determined that the company or individual has satisfied the terms of the suspension order and the license is not expired.

134.29(4) *Revocation.*

a. The department may revoke the license of a company or individual for one or more of the following:

(1) Willful disregard of, or willful or repeated violations of, this chapter or 567—Chapter 135.

(2) Fraudulent omissions or misstatements of material facts in a report or in other written or oral communications with the department.

(3) A knowing and willful failure to detect and report a material violation of UST operation and maintenance standards.

(4) Acts or omissions warranting suspension after a license was previously suspended.

b. A licensee shall immediately surrender the license after the effective date of the revocation decision.
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REVENUE DEPARTMENT[701]

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[Prior to 12/17/86, Revenue Department[730]]

DIVISION I
INFORMAL, FORMAL, ADMINISTRATIVE AND JUDICIAL REVIEW PROCEDURES APPLICABLE TO CONTESTED CASES AND OTHER PROCEEDINGS COMMENCED PRIOR TO JULY 1, 1999

701—7.1(17A) Definitions. As used in the rules contained herein the following definitions apply, unless the context otherwise requires:

"Act" means the Iowa administrative procedure Act.

"Administrative law judge" means the person assigned to preside over a proceeding whether that be the director or an administrative law judge appointed according to Iowa Code chapter 17A.

"Agency" means each board, commission, department, officer, or other administrative office or unit of the state.

"Contested case" means a proceeding, including licensing, in which the legal rights, duties or privileges of a party are required by constitution or statute to be determined by an agency after an opportunity for an evidentiary hearing.

"Department" means the Iowa department of revenue.

"Department of inspections and appeals" means the state department created by Iowa Code chapter 10A.

"Director" means the director of the department or the director's authorized representative.

"Division of appeals and fair hearings" means the division of the department of inspections and appeals responsible for holding contested case proceedings which are authorized by Iowa Code chapter 10A.

"License" means the whole or a part of any permit, certificate, approval, registration, charter, or similar form of permission required by statute.

"Licensing" means the agency process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

"Motion" has the same meaning as the term is defined in Iowa R. Civ. P. 1.431.

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

"Person" means any individual, estate, trust, fiduciary, partnership, corporation, association, governmental subdivision, or public or private organization of any character or any other person covered by the Act other than an agency.

"Petition" means application for declaratory ruling, initiation of rule-making proceedings or document filed in licensing.

"Pleadings" means protest, answer, reply or other similar document filed in a contested case proceeding.

"Presiding administrative law judge" means the administrative law judge who presides at the evidentiary hearing on the contested case.

"Proceeding" means licensing, rule making, declaratory rulings, contested cases, informal procedures.

"Protester" means any person entitled to file a protest which can culminate in a contested case proceeding.

"Review unit" means the unit composed of department employees designated by the director and the attorney general's staff who have been assigned by the director to review protests filed by taxpayers.

Unless otherwise specifically stated, the terms used in these rules promulgated by the department shall have the meaning defined by the Act.

This rule is intended to implement Iowa Code sections 10A.202(1m), 17A.22 and 421.14.

701—7.2(17A) Scope of rules. The rules contained in this chapter pertaining to practice and procedure are designed to implement the requirements of the Act and aid in the effective and efficient administration and enforcement of the tax laws of this state. These rules shall govern the practice, procedure and conduct of informal proceedings, contested case proceedings, licensing, rule making, and declaratory rulings involving:

1. Sales tax—Iowa Code sections 422.42 to 422.59.
2. Use tax—chapter 423.
3. Individual and fiduciary income tax—sections 422.4 to 422.31 and 422.110 to 422.112.
4. Franchise tax—sections 422.60 to 422.66.
5. Corporate income tax—sections 422.32 to 422.41 and 422.110 to 422.112.
6. Withholding tax—sections 422.16 and 422.17.
7. Estimated tax—sections 422.16, 422.17 and 422.85 to 422.92.
8. Motor fuel tax—chapter 452A.
9. Property tax—chapters 421, 425, 426A, 427, 427A, 428, 428A and 433 to 441.
10. Cigarette and tobacco tax—chapters 421B and 453A.
11. Inheritance, generation skipping transfer and estate tax—chapters 450, 450A, 450B and 451.
12. Local option taxes—chapter 422B.
13. Hotel and motel tax—chapter 422A.
14. Drug excise tax—chapter 453B.
15. Automobile rental excise tax—chapter 422C.
16. Environmental protection charge—chapter 424.
17. Other taxes as may be assigned to the department from time to time.

As the design of these rules is to facilitate business and advance justice, any rule contained herein, unless otherwise provided by law, may be suspended or waived by the department to prevent undue hardship in any particular instance or to prevent surprise or injustice.

This rule is intended to implement Iowa Code chapter 17A.

701—7.3(17A) Business hours. The principal office of the department in the Hoover State Office Building in Des Moines, Iowa, shall be open between the hours of 8 a.m. to 4:30 p.m. each weekday except Saturdays, Sundays and legal holidays as prescribed in Iowa Code section 4.1(34), for the purpose of receiving protests, pleadings, petitions, motions, requests for public information, copies of official documents, or for the opportunity to inspect public records.

All documents or papers required to be filed with the department by these rules shall be filed with the administrative law judge in the principal office of the department in the Hoover State Office Building, Des Moines, Iowa 50319. Requests for public information or copies of official documents or the opportunity to inspect public records shall be made in the director's office at the department's principal office.

701—7.4(17A) Computation of time, filing of documents. In computing any period of time prescribed or allowed by these rules or by an applicable statute, the day of the act, event or default from which the designated period of time begins to run shall not be included. The last day of the period so computed shall be included, unless it is a Saturday, Sunday or legal holiday, in which event the period runs until the end of the next day which is not a Saturday, Sunday or legal holiday. Legal holidays are prescribed in Iowa Code section 4.1(34).

All documents or papers required to be filed with the department shall be considered as timely filed if they are either received by the department's principal office or are postmarked for delivery to the department's principal office within time limits as prescribed by law or by rules or orders of the department.

In all cases where the time for the filing of a protest or the performance of any other act shall be fixed by law, the time so fixed by law shall prevail over the time fixed in these rules.

701—7.5(17A) Form and style of papers. All pleadings, petitions, briefs and motions or other documents filed with the department shall be typewritten, shall have a proper caption, and a signature and copies as herein provided or as specified in some other rule.

7.5(1) Papers shall be typed on only one side of plain white paper. Pleadings, petitions, motions, orders and any other papers allowed or required to be filed by these rules may be on any size paper. Citations should be underscored.

7.5(2) The proper caption shall be placed in full upon the first paper filed.

7.5(3) The signature of the petitioner, party, or authorized representative shall be subscribed in writing to the original of all pleadings, petitions, briefs or motions and shall be an individual and not a firm name except that the signature of a corporation shall be the name of the corporation by one of its active officers. The name and mailing address of the party or the party's representative actually signing shall be typed or printed immediately beneath the written signature. The signature shall constitute a certification that the signer has read the document; that to the best of the signer's knowledge, information and belief every statement contained in the document is true and no such statement is misleading; and that it is not interposed for delay.

A taxpayer or the taxpayer's representative using E-mail or other electronic means to submit an income tax return, a sales tax or use tax return, a return for any other tax administered by the department, an application for a sales tax permit or other permit, a deposit form for remitting withholding tax or other taxes administered by the department, or any other document to the department may use an electronic signature or a signature designated by the department in lieu of a handwritten signature. To the extent that a taxpayer or the taxpayer's representative submits a tax return, deposit document, application or other document by E-mail or other electronic means to the department with an electronic signature or signature designated by the department, the taxpayer should include in the record of the document the taxpayer's federal identification number so that the taxpayer's identity is established. For purposes of this rule, "electronic signature" means an electronic sound, symbol, or process attached to or logically associated with a tax return, deposit document, or other document filed with the department and executed or adopted by a person with the intent to sign the return, deposit document, or other document filed with the department. For purposes of this rule, "signature designated by the department" means a symbol or other information provided by the department to the taxpayer or the taxpayer's representative that is to serve instead of the handwritten signature of the taxpayer.

In a situation where the taxpayer or the taxpayer's representative has submitted a return or other document to the department by E-mail, the taxpayer should include the taxpayer's E-mail address in the record of the document. However, notwithstanding the above information, a taxpayer may not submit a tax return or other document to the department with an electronic signature when a handwritten signature is required with the return or document by federal or state law.

7.5(4) Every pleading (other than protest) or motion or brief shall bear proof of service upon the opposing party as provided by the Iowa Rules of Civil Procedure.

7.5(5) Except as otherwise provided in these rules or ordered by the department, an original copy only of every pleading, brief, motion or petition shall be filed.

7.5(6) All copies shall be clear and legible but may be on any weight paper.

Upon motion of an opposing party or on its own, the department may, in its discretion, if a person or party has failed to comply with this rule, require such person or party to follow the provisions of this rule pointing out the defects and details needed to comply with the rule prior to filing.

This rule is intended to implement Iowa Code chapters 17A and 554D and section 421.17.

701—7.6(17A) Persons authorized to practice before the department. Due to the complex questions involved and the technical aspects of taxation, persons are encouraged to seek the aid, advice, assistance and counsel of practicing attorneys and certified public accountants.

The right to practice before the department in connection with any proceeding shall be limited to the following classes of persons:

1. Taxpayers who are natural persons representing themselves.
2. Attorneys duly qualified and entitled to practice in the courts of the state of Iowa.

3. Attorneys who are entitled to practice before the highest court of record of any other state and who have complied with Iowa Ct. R. 31.14.

4. Accountants who are authorized, permitted, or licensed under Iowa Code chapter 542C.

5. Duly authorized directors or officers of corporations representing the corporation of which they are respectively a director or officer, excluding attorneys who are acting in the capacity of a director or officer of a corporation and who have not met the requirements of the third classification above.

6. Partners representing their partnership.

7. Fiduciaries.

8. Government officials authorized by law.

9. Enrolled agents, currently enrolled under 31 CFR §10.6 for practice before the Internal Revenue Service, representing a taxpayer in proceedings under division II, Iowa Code chapter 422.

Any person appearing in any proceeding before the department on behalf of another must have on file with the department a power of attorney.

No person who has served as an official or employee of the department shall within a period of two years after the termination of such service or employment appear before the department or receive compensation for any services rendered on behalf of any person, firm, corporation, or association in relation to any case, proceeding, or application with respect to which the person was directly concerned and in which the person personally participated during the period of service or employment.

This rule is intended to implement Iowa Code chapter 17A.

701—7.7(17A) Resolution of tax liability. Unless a proper protest has been filed as provided hereinafter, persons interested in any tax liability, refund claim, licensing or any other tax matters shall discuss the resolution of such matters with appropriate personnel as designated by the billing.

In the event that a proper protest has been filed as provided hereinafter, the appropriate department personnel, when authorized by the review unit, shall have the authority to discuss the resolution of any matter in the protest either with the protester or the protester's representative. The appropriate personnel shall report their activities in this regard to the review unit and the unit shall be authorized to approve or reject any recommendations made by the appropriate personnel to resolve a protest.

This rule is intended to implement Iowa Code chapter 17A.

701—7.8(17A) Protests. Any person wishing to contest an assessment, denial of refund claim, or any other department action, except licensing, which may culminate in a contested case proceeding shall file a protest, in writing, with the department within the time prescribed by the applicable statute or rule for filing notice of application to the director for a hearing. The protest must be either delivered to the department by United States Postal Service, by ordinary, certified, or registered mail, directed to the attention of the administrative law judge, personally delivered to the office of the administrative law judge, or be served on the department by personal service during business hours. For the purpose of mailing, a protest is considered filed on the date of the postmark. It is considered filed the date personal service or personal delivery to the office of the administrative law judge is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing. The period for appealing agency action relating to refund claims is the same statutory period for contesting an assessment. For assessments issued before January 1, 1995, the time period for filing a protest to an assessment cannot be extended by filing a refund claim. Failure to timely file a written protest will be construed as a waiver of opposition to the matter involved unless on the director's own motion, pursuant to statutory authority, the power of abatement is exercised. The review unit may seek dismissal of protests which are not in the proper form as provided by this rule. See subrule 7.11(2) for dismissals.

For refund claims filed on or after January 1, 1995, if the department has not granted or denied a refund claim within six months of filing the claim, the refund claimant may file a protest. Even though a protest is so filed, the department is entitled to examine and inspect the refund claimant's records to verify the refund claim.

Notwithstanding the above, the taxpayer who fails to timely protest an assessment issued on or after January 1, 1995, may contest the assessment by paying the whole assessed tax, interest, and penalty

and by filing a refund claim within the time period provided by law for filing such claim. However, in the event that such assessment involves divisible taxes, which are not timely protested, namely, an assessment which is divisible into a tax on each transaction or event, the taxpayer can contest the assessment by paying a portion of the assessment and filing a refund claim within the time period provided by law. In this latter instance, the portion paid must represent any undisputed portion of the assessment and must also represent the liability on a transaction or event for which, if the taxpayer is successful in contesting the portion paid, the unpaid portion of the assessment would be canceled. *Flora v. United States*, 362 U.S. 145, 4 L.Ed. 2d 623, 80 S.Ct. 630 (1960); *Higginbotham v. United States*, 556 F.2d 1173 (4th Cir. 1977); *Steele v. United States*, 280 F.2d 89 (8th Cir. 1960); *Stern v. United States*, 563 F. Supp. 484 (D.Nev. 1983); *Drake v. United States*, 355 F. Supp. 710 (E.D. Mo. 1973). Any such protest filed is limited to the issues covered by the amounts paid for which a refund was requested and denied by the department. Thereafter, if the department does not grant or deny the refund within six months of the filing of the refund claim or if the department denies the refund, the taxpayer may file a protest as authorized by this rule.

All of the taxes administered by the department can be divisible taxes, except individual income tax, fiduciary income tax, corporation income tax, and franchise tax. The following noninclusive examples illustrate the application of the divisible tax concept.

EXAMPLE A: X is assessed withholding income taxes, penalty and interest, as a responsible party on eight employees. X fails to timely protest the assessment. X contends that X is not a responsible party. If X is a responsible party, X was required to make monthly deposits of the withholding taxes. In this situation, the withholding taxes are divisible. Therefore, X can pay an amount of tax, penalty and interest attributable to one employee for one month and file a refund claim within the time period provided by law since if X is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

EXAMPLE B: Y is assessed sales tax, interest, and penalty for electricity purchased and used to power a piece of machinery in Y's manufacturing plant. Y fails to timely protest the assessment. Y was billed monthly for electricity by the power company to whom Y had given an exemption certificate. Y contends that the particular piece of machinery is used directly in processing tangible personal property for sale and that, therefore, all of the electricity is exempt from sales tax. In this situation, the sales tax is divisible. Therefore, Y can pay an amount of tax, penalty and interest attributable to one month's electrical usage in that machinery and file a refund claim within the time period provided by law since if Y is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

The protest shall be brought by and in the name of the interested or affected person or by and in the full descriptive name of the fiduciary legally entitled to institute a proceeding on behalf of the person or by an intervenor in contested case proceedings. In the event of a variance in the name set forth in the protest and the correct name, a statement of the reason for the discrepancy shall be set forth in the protest.

A protest which is filed shall contain:

7.8(1) A caption in the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	
(state taxpayer's name, address and	*	PROTEST
designate type of proceeding, e.g.,	*	DOCKET NO. _____
income tax refund claim)	*	(filled in by Department)

7.8(2) Substantially state in separate numbered paragraphs the following:

a. Proper allegations showing:

(1) Date of assessment.

(2) Date of refund denial.

(3) Whether, for assessments issued on or after January 1, 1995, protester failed to timely appeal the assessment and, if so, the date of payment and the date of filing the refund claim.

(4) Whether, for refund claims filed on or after January 1, 1995, the protest involves the appeal of a refund claim after six months from the date of filing the refund claim because the department failed to deny the claim.

(5) Attach a copy of the assessment, refund claim, and refund denial.

(6) Other items that the protester wishes to bring to the attention of the department.

b. The type of tax, the taxable period or periods involved and the amount in controversy;

c. List each error alleged to have been committed in a separate paragraph. For each error listed, provide an explanation of the error and all relevant facts related to the error;

d. Refer to any particular statute or statutes and any rule or rules involved, if known;

e. Description of records or documents which were not available or were not presented to department personnel prior to the filing of the protest, if any, and provide copies of any records or documents that were not previously presented to the department;

f. Any other matters deemed relevant and not covered in the above paragraphs;

g. The desire of protester to waive informal or contested case proceedings if it is desired; unless the protester so indicates a waiver, informal procedures will be initiated;

h. A statement setting forth the relief sought by protester;

i. The signature of the protester or that of the protester's representative, the addresses of the protester and of the protester's representative, and the telephone number of the protester or the protester's representative.

j. Attach a copy of power of attorney for protester's representative.

Upon receipt of the protest, the administrative law judge shall docket the protest in a docket kept for that purpose and shall assign a number to the case which number shall be placed on all subsequent pleadings filed in the case. An original and two copies of the protest shall be filed.

The protester may amend the protest at any time prior to the commencement of the evidentiary hearing. The department can request that protester amend the protest for purposes of clarification.

7.8(3) Denial of renewal of vehicle registration or denial of issuance or renewal, or suspension of driver's license. A person who has had an application for renewal of vehicle registration denied or has been denied the issuance of a driver's license or the renewal of a driver's license, or has had a driver's license suspended may file a protest with the department if the denial of the issuance or renewal or the suspension is because the person owes delinquent taxes.

The issues raised in a protest by the person, which are limited to a mistake of fact, may include but are not limited to:

1. The person has the same name as the obligor but is not the correct person.
2. The amount in question has been paid.
3. The person has made arrangements with the department to pay the amount.

701—7.9(17A) Identifying details. Any person may, at any time, petition the administrative law judge to delete identifying details concerning the person from any document relating to any proceedings as defined in rule 701—7.1(17A), prior to disclosure to members of the public.

If the petition concerns information which is not a part of a contested case, the petition shall be in the form of a request to delete identifying details; if part of a contested case, the petition shall be in the form of a motion to delete identifying details. All motions to delete shall conform to subrule 7.17(3).

The motion or request shall contain the following:

1. The name of the person requesting deletion and the docket number of the proceeding, if applicable.

2. The legal basis for their request for deletion; such as, release of the material would be a clearly unwarranted invasion of personal privacy or the material is a trade secret or of advantage to competitors. A corporation may not claim an unwarranted invasion of privacy.

3. A precise description of the document, report or other material in the possession of the department from which the deletion is sought, and a precise description of the information to be deleted. If deletion is sought from more than one document, each document and the materials sought to be deleted from it shall be listed in separate paragraphs. Also contained in each separate paragraph shall be a statement of the legal basis for the deletion requested in that paragraph, such as, the material sought to be deleted is a trade secret or its release would give advantage to competitors and serve no public purpose.

4. An affidavit in support of deletion must accompany each motion or request. The affidavit must be sworn to by a person familiar with the facts asserted within it and shall contain a clear and concise explanation of the facts justifying deletion, not merely the legal basis for deletion.

5. All affidavits shall contain a general statement that the information sought to be deleted is not available to the public from any source or combination of sources, direct or indirect, and if the grounds for deletion is that the release of information would give advantage to competitors, the general statement that the release would serve no public purpose.

A ruling on a request or motion shall not become the final decision of the department until 30 days after the date of the ruling unless there is an appeal to, or review on motion of, the director within 30 days of the date of the ruling.

701—7.10(17A) Docket. The administrative law judge shall maintain a docket of all proceedings and each of the proceedings shall be assigned a number. Every matter coming within the purview of these rules shall be assigned a docket number which shall be the official number for the purposes of identification. Upon receipt of a protest, petition for declaratory ruling or petition to initiate rule-making proceedings, the proceeding will be docketed and assigned a number, and the parties notified thereof. The number shall be placed by the parties on all papers thereafter filed in the proceeding.

701—7.11(17A) Informal procedures and dismissals of protests.

7.11(1) *Informal procedures.* Persons are encouraged to utilize the informal procedure provided herein so that a settlement may be reached between the parties without the necessity of initiating contested case proceedings. Therefore, unless the protester indicates a desire to waive the informal procedures in the protest or the department waives informal procedures upon notification to the protester, such informal procedures will be initiated as herein provided upon the filing of a proper protest.

a. Review unit. A review unit is created within the department and, subject to the control of the director, the unit will:

(1) Review and evaluate the validity of all protests made by taxpayers from the agency action.

(2) Determine the correct amount of tax owing or refund due.

(3) Determine the best method of resolving the dispute between the protester and the department.

(4) Assign protests to the appropriate divisions or sections of the department for resolution.

(5) Take further action regarding the protest, including any additions and deletions to the audit, as may be warranted by the circumstances to resolve the protest, including a request for an informal conference.

(6) Determine whether the protest complies with rule 701—7.8(17A) and request any amendments to the protest or additional information.

After assignment of the protest, the section or division responsible may concede any items contained in the protest which it determines should not be controverted by the department. If the protester has not waived informal procedures, the section or division responsible may request the protester and the protester's representative, if any, to attend an informal conference with the responsible section or division to explore the possibility of reaching a settlement without the necessity of initiating contested case proceedings or of narrowing the issues presented in the protest if no settlement can be made.

If informal procedures have been waived, findings dealing with the issues raised in the protest may be issued unless the issues may be more expeditiously determined in another manner or it is determined that findings are unnecessary. The protester will be notified of the decision on the issues in controversy.

Nothing herein will prevent the section or division responsible and the protester from mutually agreeing on the manner in which the protest will be informally reviewed.

b. *Settlements.* If a settlement is reached during informal procedures, the administrative law judge shall be notified. The administrative law judge shall issue an order and serve it upon all parties which order shall set forth that a settlement was reached and shall terminate the case.

7.11(2) *Dismissal of protests.*

a. Whether informal procedures have been waived or not, the failure of the protester to timely file a protest or to pursue the protest may be grounds for dismissal of the protest by the administrative law judge. If informal procedures have not been waived, the failure of the protester to present evidence or information requested by the review unit shall constitute grounds for the administrative law judge to dismiss the protest. For purposes of this subrule, an evasive or incomplete response will be treated as a failure to present evidence or information. The failure of protester to file a protest in the format required by rule 7.8(17A) may be grounds for dismissal of the protest by the administrative law judge.

b. If the department seeks to have the protest dismissed, the review unit shall file a motion to dismiss with the office of the administrative law judge and serve a copy of the motion on protester. Protester may file a resistance to the motion within 20 days of the date of service of the motion. If no resistance is so filed, the administrative law judge shall immediately enter an order dismissing the protest. If a resistance is filed, the review unit has 10 days from the date of the filing of the resistance to decide whether to withdraw its motion and so notify the administrative law judge and protester. If no such notice is issued by the review unit within the 10-day period, the administrative law judge shall issue a notice for a contested case proceeding on the motion as prescribed by rule 7.14(17A) except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be dismissed. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such dismissal proceedings.

c. If a motion to dismiss is filed and is unresisted, a protest so dismissed may be reinstated by the administrative law judge for good cause shown if an application for reinstatement is filed with the office of the administrative law judge within 30 days of the date the protest was dismissed. The application shall set forth all reasons and facts upon which the protester relies in seeking reinstatement of the protest. The review unit shall review the application and notify the protester whether the application is granted or denied. If the review unit denies the application to reinstate the protest, the protester has 30 days from the date the application for reinstatement was denied in which to request, in writing, a formal hearing before the administrative law judge on the reinstatement. When a written request is received, the administrative law judge shall issue a notice as prescribed in rule 7.14(17A) except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be reinstated. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such reinstatement proceedings.

d. Once contested case proceedings have been commenced, whether informal proceedings have been waived or not, it shall be grounds for a motion to dismiss that a protester has either failed to diligently pursue the protest or refuses to comply with requests for discovery set forth in rule 7.15(17A).

701—7.12(17A) Answer. The department may, in lieu of findings, file an answer. When findings are issued, the department will file an answer within 30 days of receipt of written notification from protester stating disagreement with the findings. The answer shall be filed with the department's administrative law judge.

In the event that the protester does not so respond in writing to the findings issued on matters covered by subrule 7.11(1) within 30 days after being notified, the department may seek dismissal of the protest pursuant to subrule 7.11(2).

The answer of the department shall be drawn in a manner as provided by the Iowa rules of civil procedure for answers filed in Iowa district courts.

Each paragraph contained in the answer shall be numbered to correspond, where possible, with the paragraphs of the protest. An original copy only of the answer shall be filed with the administrative law judge and shall be signed by the department's counsel or representative.

The department shall forthwith serve a copy of the answer upon the representative of record, or if there is no representative of record then upon the protester, and shall file proof of service with the administrative law judge at the time of filing of the answer. The department may amend its answer at any time prior to the commencement of the evidentiary hearing.

The provisions of rule 7.12(17A) shall be considered as a part of the informal procedures since a contested case proceeding, at the time of filing the answer, has not yet commenced. However, an answer shall be filed pursuant to this rule whether or not informal procedures have been waived by the protester or the department.

Notwithstanding the above portions of this rule, if a taxpayer, who has filed a protest on or after January 1, 1995, makes a written demand for a contested case proceeding, as authorized by subrule 7.14(2), after a period of six months from the filing of a proper protest, the department shall file its answer within 30 days after receipt of the demand. If the department fails to file its answer within this 30-day period, interest shall be suspended, if the protest involves an assessment, from the time that the department was required to answer until the date that the department files its answer and, if the protest involves a refund, interest shall accrue on the refund at double the rate from the time the department was required to answer until the date that the department files its answer.

This rule is intended to implement Iowa Code sections 10A.202(1)*"m,"*17A.22, 421.14 and 421.60.

701—7.13(17A) Subpoenas. Prior to the commencement of a contested case, the department shall have the authority to subpoena books, papers, records and shall have all other subpoena powers conferred upon it by law. Subpoenas in this case shall be issued by the department's administrative law judge.

This rule is intended to implement Iowa Code sections 10A.202(1)*"m,"*17A.22 and 421.14.

701—7.14(17A) Commencement of contested case proceedings.

7.14(1) Payment of tax or bond required prior to contested case proceedings for assessments made prior to January 1, 1991.

a. Effective date—payment or bond required. Effective for contested case proceedings for unpaid tax, penalty, interest, or fees commenced in response to assessments made on or after January 1, 1987, and prior to January 1, 1991, the taxpayer must pay prior to the commencement of contested case proceedings, all of the assessed tax, penalty, interest, or fees or, upon a showing of good cause, a bond may be posted in lieu of payment of the amount of the assessment that is in dispute.

b. Cases applicable. The provisions of this subrule only apply to those contested case proceedings where a tax, penalty, interest, or fees, or any combination of them, which has not been previously paid prior to the commencement of contested case proceedings, is at issue.

c. Cases not applicable. This subrule does not apply to protest proceedings involving only the denial of refund claims. Nor does this subrule apply to a taxpayer's appeal or protest pending in informal procedures involving an unpaid tax, penalty, interest, or fees.

d. Time disputed tax, penalty, interest, or fees must be paid. Unless a bond has been posted as provided in subrule 7.14(1), paragraph *"f,"* all of the disputed tax, penalty, interest, or fees assessed computed to the date of payment must be paid in full, within 30 days after the date the answer is filed by the department. Undisputed amounts are not eligible for a bond and must be paid with the payment of the disputed amount, or with the posting of the bond.

e. Payment deemed made under protest. Unless the taxpayer declares otherwise in writing, the payment of that portion of the assessed tax, penalty, interest, or fees in dispute after the filing of the department's answer, shall be deemed to have been paid under protest and, if upon resolution of the protest, the amount paid is in excess of the correct tax, penalty, interest, or fees due, the excess shall be refunded to the taxpayer or other persons entitled with interest as provided by law, subject to any right of offset.

f. Bond in lieu of payment. Within 30 days after the date the answer is filed by the department, and upon filing an application showing good cause, the taxpayer may, in lieu of payment, post a bond securing the payment of that portion of the assessed tax, penalty, interest, or fees which is in dispute accrued to the date the bond is posted. A taxpayer is not permitted to refuse to pay the portion of the assessed amount not in dispute until all disputed issues have been resolved. The uncontested portion of the assessment must be paid and a bond is only permitted to be posted in lieu of payment of the amount in dispute. The bond shall be payable to the department for the use of the state of Iowa and shall be conditioned upon the full payment of the tax, penalty, interest, or fees that are found to be due which remain unpaid upon the resolution of the contested case proceedings. The bond shall be for the full amount of the assessed tax, penalty, interest, or fees that is in dispute, computed to the day the bond is posted. Provided upon application of the taxpayer or the department, the department's administrative law judge may, upon hearing, fix a greater or lesser amount to reflect changed circumstances, but only after ten days' prior notice is given to the department or the taxpayer as the case may be.

g. Type of bond. A personal bond, without a surety, is only permitted if the taxpayer posts with the department's administrative law judge, cash, a cashier's check, a certificate of deposit, or other marketable securities with a readily ascertainable value which is equal in value to the total amount of the bond required. If a surety bond is posted, the surety on the bond may be either personal or corporate. The provisions of this subrule and Iowa Code chapter 636 relating to personal and corporate sureties shall govern.

h. Procedure for posting bond. In the event the taxpayer desires to post bond in lieu of payment of the amount of the tax, penalty, interest, or fees claimed to be due which is in dispute, an application in writing, together with the bond must be filed with the administrative law judge within 30 days after the department's answer is filed. The application must state the reasons why good cause exists for posting a bond in lieu of payment. A copy of the application with a copy of the bond attached must be given the department's representative by ordinary mail and thereafter if the taxpayer and the department agree on the bond, it shall be approved by the administrative law judge. If an agreement on the bond is not reached and the department has not filed with the administrative law judge written objections to granting the bond within ten days after the postmark date of the notice of application, the administrative law judge shall approve the bond, if the bond is otherwise in proper form and in compliance with the law. In the event objections are filed by the department, the administrative law judge shall set the objections down for hearing with written notice to be given the taxpayer and the department at least ten days prior to the hearing. If upon hearing the department's objections are overruled, the bond shall be approved. If the objections are sustained, and the taxpayer fails to pay the amount of the tax, penalty, interest, or fees claimed to be due or cure the bond defects, if permitted by the administrative law judge's order, within 30 days after the administrative law judge's decision, the protest shall be dismissed and the dismissal shall be with prejudice, if the time for protesting the department action has elapsed.

i. Reasons constituting good cause. The financial hardship of the taxpayer as evidenced by the books and records of the taxpayer is an example of a good cause for posting a bond in lieu of paying the tax, penalty, interest, or fees in dispute. In addition, posting of a bond will be allowed upon agreement of the protester and the department.

j. Form of surety bond. The surety bond posted shall be in substantially the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF	*	
		SURETY BOND
(Taxpayer's Name,	*	
Address and designate	*	

proceeding, e.g., income,	*	
sales, etc.)	*	
	*	DOCKET NO.

KNOW ALL PERSONS BY THESE PRESENTS:

That we ____(taxpayer)____ as principal, and ____(surety)_____, as surety, of the county of _____ , and State of Iowa, are held and firmly bound unto the Iowa Department of Revenue for the use of the State of Iowa, in the sum of $ _____ dollars, lawful money of the United States, for the payment of which sum we jointly and severally bind ourselves, our heirs, devisees, successors and assigns firmly by these presents. The condition of the foregoing obligations are, that, whereas the above named principal has protested an assessment of tax, penalty, interest, or fees or any combination of them, made by the Iowa Department of Revenue, now if the principal _____ shall promptly pay the amount of the assessed tax, penalty, interest, or fees found to be due upon the resolution of the contested case proceedings, then this bond shall be void, otherwise to remain in full force and effect.

Dated the _____ day of _____ , 20 ____ .

_____
Principal

_____
Surety

_____
Surety

(corporate acknowledgment if surety is a corporation)

AFFIDAVIT OF PERSONAL SURETY

STATE OF IOWA
ss.
COUNTY OF)

I hereby swear or affirm that I am a resident of Iowa and am worth beyond my debts the amount set opposite my signature below in the column entitled, "Worth Beyond Debts", and that I have property in the State of Iowa, liable to execution equal to the amount set opposite my signature in the column entitled "Property in Iowa Liable to Execution".

Signature	Worth Beyond Debts	Property in Iowa Liable to Execution
_____	$ _____	$ _____
Surety (type name)		
_____	$ _____	$ _____
Surety (type name)		

Subscribed and sworn to before me the undersigned Notary Public this _____ day of _____, 20 ____.

_____
(Seal) Notary Public in and for the State of Iowa

k. Duration of bond. The bond shall remain in full force and effect until the conditions of the bond have been fulfilled or until the bond is otherwise exonerated by the administrative law judge.

l. Exoneration of the bond. Upon conclusion of the contested case administrative proceedings, the bond shall be exonerated by the administrative law judge when any of the following events occur: upon full payment of the tax, penalty, interest, or fees found to be due; upon filing a bond for the purposes of judicial review; or if no additional tax, penalty, interest, or fees are found to be due that have not been previously paid, upon entry of the order resolving the contested case proceedings.

m. Failure to pay amount found to be due. If upon resolution of the contested case proceedings, the taxpayer fails to pay the tax, penalty, interest, or fees assessed or found to be due, the bond shall be forfeited by the administrative law judge and the department may sell or liquidate any property posted by the taxpayer, or bring suit against the surety on the bond and apply the amount recovered to the tax, penalty, interest, or fees due. Any excess over the amount due shall be refunded to the taxpayer or other persons entitled as provided by law, subject to any right of offset.

n. Dismissal of protest—failure to pay or post bond. The administrative law judge must dismiss the protest in the following circumstances:

(1) If the taxpayer fails to pay the amount of the assessed tax, penalty, interest, or fees or fails to post a bond with the administrative law judge for the amount of the assessment in dispute within 30 days after the filing of the department's answer;

(2) The taxpayer fails to pay the disputed tax, penalty, interest, or fees or fails to file an acceptable bond, if permitted by order of the administrative law judge, within 30 days after the order sustaining the department's objection to the bond. The dismissal shall be with prejudice if the time for protesting the department's action has elapsed at the time of dismissal. The dismissal of the protest cannot be avoided or circumvented when payment has not been made or a bond posted by a withdrawal of or amendment to the protest after the answer has been filed.

7.14(2) Demand or request for contested case proceedings. A demand or request by the protester for the commencement of contested case proceedings must be in writing and either be mailed to the department by United States Postal Service ordinary, certified, or registered mail directed to the attention of the administrative law judge, or be served on the department by personal service or by personal delivery of the demand or request to the office of the administrative law judge during business hours. The demand or request is considered filed on the date of the postmark or the date personal service is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

Contested case proceedings will be commenced by the department's administrative law judge by delivery of notice by ordinary mail directed to the parties, after a demand or request is made (1) by the protester and the filing of the answer, if one is required, which demand or request may include a date to be set for the hearing, or (2) upon filing of the answer, if a request or demand for contested case proceedings has not been made by the protester. The notice will be given by the department's administrative law judge. Both the department's administrative law judge and the presiding administrative law judge may grant a continuance of the hearing. Any change in the date of the hearing shall be set by the presiding administrative law judge. Either party may apply to the presiding administrative law judge for a specific date for the hearing. The notice shall include:

1. A statement of the time (which shall allow for a reasonable time to conduct discovery), place and nature of the hearing;
2. A statement of the legal authority and jurisdiction under which the hearing is held;
3. A reference to the particular sections of the statutes and rules involved;
4. A short and plain statement of the matters asserted, including the issues.

After the delivery of the notice commencing the contested case proceedings, the parties may file further pleadings or amendments to pleadings as they desire. However, any pleading or amendment thereto which is filed within seven days prior to the date scheduled for the hearing or filed on the date of the hearing shall constitute good cause for the party adversely affected by the pleading or amendment to seek and obtain a continuance.

This rule is intended to implement Iowa Code sections 10A.202(1*m*), 17A.12 and 421.8A.

701—7.15(17A) Discovery. The rules of the Supreme Court of the state of Iowa, as amended, applicable in civil proceedings with respect to depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admission shall apply to discovery procedures in contested case proceedings. Disputes concerning discovery shall be resolved by the department's administrative law judge. If necessary a hearing shall be scheduled, with reasonable notice to the parties and upon hearing an appropriate order shall be issued by the department's administrative law judge.

When the department relies on a witness in a contested case, whether or not a departmental employee, who has made prior statements or reports with respect to the subject matter of the witness' testimony, it shall, on request, make such statements or reports available to a party for use on cross-examination, unless those statements or reports are otherwise expressly exempt from disclosure by constitution or statute. Identifiable departmental records that are relevant to disputed material facts involved in a contested case, shall, upon request, promptly be made available to the party unless the requested records are expressly exempt from disclosure by constitution or statute.

Evidence obtained in such discovery may be used in contested case proceedings if that evidence would otherwise be admissible in the contested case proceeding.

This rule is intended to implement Iowa Code sections 10A.202(1*m*), 17A.22 and 421.14.

701—7.16(17A) Prehearing conference. The administrative law judge, upon motion, or upon the written request of a party, shall direct the parties to appear at a specified time and place before the administrative law judge for a prehearing conference to consider:

1. The possibility or desirability of waiving any provisions of the Act relating to contested case proceedings by written stipulation representing an informed mutual consent.
2. The necessity or desirability of setting a new date for hearing.
3. The simplification of issues.
4. The necessity or desirability of amending the pleadings either for the purpose of clarification, amplification or limitation.
5. The possibility of agreeing to the admission of facts, documents or records not really controverted, to avoid unnecessary introduction of proof.
6. The procedure at the hearing.
7. Limiting the number of witnesses.
8. The names and identification of witnesses and the facts each party will attempt to prove at the hearing.
9. Conduct or schedule of discovery.
10. Such other matters as may aid, expedite or simplify in the disposition of the proceeding.

Since stipulations are encouraged it is expected and anticipated that the parties proceeding to a hearing will stipulate to evidence to the fullest extent to which complete or qualified agreement can be reached including all material facts that are not or should not fairly be in dispute.

Any action taken at the prehearing conference shall be recorded in an appropriate order, unless the parties enter upon a written stipulation as to such matters or agree to a statement thereof made on the record by the administrative law judge.

When an order is issued at the termination of the prehearing conference, a reasonable time shall be allowed to the parties to present objections on the ground that it does not fully or correctly embody the agreements at such conference. Thereafter, the terms of the order or modification thereof shall determine the subsequent course of the proceedings relative to matters it includes, unless modified to prevent manifest injustice.

Without the necessity of proceeding to an evidentiary hearing in a contested case, the parties may agree in writing to informally dispose of the case by stipulation, agreed settlement, consent order or by another method agreed upon. If such informal disposition is utilized, the parties shall so indicate to the administrative law judge that the case has been settled.

If either party to the contested case proceeding fails to appear at the prehearing conference, or fails to request a continuance, or fails to submit evidence or arguments which the party wishes to be considered in lieu of appearance, the opposing party may move for dismissal. The motion shall be made in accordance with subrule 7.17(3).

This rule is intended to implement Iowa Code section 17A.12.

701—7.17(17A) Contested case proceedings. Unless the parties to a contested case proceeding have, by written stipulation representing an informed mutual consent, waived the provisions of the Act relating to such proceedings, contested case proceedings shall be initiated and culminate in an evidentiary hearing open to the public. Evidentiary hearings shall be held at the department's principal office, Hoover State Office Building, Des Moines, Iowa 50319, except that a case may be assigned for hearing elsewhere only for extraordinary circumstances or when the protester would otherwise be deprived of due process of law. By agreement of the parties, the hearing may be conducted at another place or by other means, for example, through the fiber optic network or by telephone. Parties shall be notified at least 30 days in advance of the date and place of the hearing.

7.17(1) *Conduct of proceedings.* A proceeding shall be conducted by an administrative law judge who, among other things, shall:

a. Open the record and receive appearances;
b. Administer oaths, and issue subpoenas;
c. Enter the notice of hearing into the record;
d. Receive testimony and exhibits presented by the parties;
e. In the administrative law judge's discretion, interrogate witnesses;
f. Rule on objections and motions;
g. Close the hearing;
h. Issue an order containing findings of fact and conclusions of law.

Evidentiary proceedings shall be oral and open to the public and shall be recorded either by mechanical means or by certified shorthand reporters. Parties requesting that the hearing be recorded by certified shorthand reporters shall bear the appropriate costs. The record of the oral proceedings or the transcription thereof shall be filed with and maintained by the department for at least five years from the date of the decision.

An opportunity shall be afforded to the parties to respond and present evidence and argument on all issues involved and to be represented by counsel at their own expense. Unless otherwise directed by the administrative law judge, evidence will be received in the following order:

(1) Protester (2) intervenor (if applicable) (3) department (4) rebuttal by protester (5) oral argument by parties (if necessary).

If the protester or the department appear without counsel or other representative who can reasonably be expected to be familiar with these rules, the administrative law judge shall explain to the parties the rules of practice and procedure and generally conduct a hearing in a less formal manner than that used when the parties have such representatives appearing upon their behalf. It should be the purpose of the administrative law judge to assist any party appearing without such representative to the extent necessary to allow the party to fairly present evidence, testimony and arguments on the issues. The administrative law judge shall take whatever steps may be necessary and proper to ensure that all evidence having probative value is presented and that each party is accorded a fair hearing.

If the parties have mutually agreed to waive the provisions of the Act in regard to contested case proceedings, the hearing will be conducted in a less formal manner than when an evidentiary hearing is conducted.

If a party fails to appear in a contested case proceeding after proper service of notice, the administrative law judge may, upon the judge's own motion or upon the motion of the party who has appeared, adjourn the hearing or proceed with the hearing and make a decision in the absence of the party.

Contemptuous conduct by any person appearing at a hearing shall be grounds for the person's exclusion from the hearing by the administrative law judge.

A stipulation by the parties of the issues or a statement of the issues in the notice commencing the contested case cannot be changed by the presiding administrative law judge without the consent of the parties. The presiding law judge shall not on their own motion change or modify the issues agreed upon by the parties. Notwithstanding the provisions of this paragraph, a party within a reasonable time prior to the hearing may request that a new issue be addressed in the proceedings, except that the request cannot be made after the parties have stipulated to the issues.

The department's administrative law judge may forward the appeal file to the division of appeals and fair hearings of the department of inspections and appeals for the purpose of scheduling and conducting a hearing on the protest. Before doing so the department's administrative law judge shall secure the consent of the division of appeals and fair hearings. The parties shall be notified whether or not the division of appeals and fair hearings will schedule and conduct the hearing.

7.17(2) *Rules of evidence.* In evaluating evidence, the department's experience, technical competence, and specialized knowledge may be utilized.

a. Oath. All testimony presented before the administrative law judge shall be given under oath which the administrative law judge has authority to administer.

b. Production of evidence and testimony. The administrative law judge may issue subpoenas to a party on request, as permitted by law, compelling the attendance of witnesses and the production of books, papers, records or other real evidence.

(1) *Subpoena.* When a subpoena is desired after the commencement of a contested case proceeding, the proper party shall indicate to the department's administrative law judge the name of the case, the docket number and the last-known addresses of the witnesses to be called. If evidence other than oral testimony is required, each item to be produced must be adequately described. When properly prepared by the department's administrative law judge, the subpoena will be returned to the requesting party for service. Service may be made in any manner allowed by law before the hearing date of the case which the witness is required to attend. No costs for serving a subpoena will be allowed if it is served by any person other than the sheriff. Subpoenas requested for discovery purposes shall be issued by the department's administrative law judge.

(2) Reserved.

c. Admissibility of evidence.

(1) *Evidence having probative value.* Although the administrative law judge is not bound to follow the technical common law rules of evidence, a finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Therefore, the administrative law judge may admit and give probative effect to evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The administrative law judge shall give effect to the rules of privilege recognized by law. Evidence not provided to a requesting party through discovery shall not be admissible at the hearing. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced substantially, any part of the evidence may be required to be submitted in verified written form by the administrative law judge.

Objections to evidentiary offers may be made at the hearing and the administrative law judge's ruling thereon shall be noted in the record.

(2) *Evidence of a federal determination.* Evidence of a federal determination whether it be a treasury department ruling or regulation or determination letter, a federal court decision or an internal revenue service assessment relating to issues raised in the proceeding shall be admissible, and the protester shall be presumed to have conceded the accuracy of it unless the protester specifically states wherein it is erroneous.

(3) *Copies of evidence.* A copy of any book, record, paper or document may be offered directly in evidence in lieu of the original, if the original is not readily available or if there is no objection. Upon request, the parties shall be given an opportunity to compare the copy with the original, if available.

(4) *Stipulations.* Approval of the presiding administrative law judge is not required for stipulations of the parties to be used in contested case proceedings. In the event the parties file a stipulation in the proceedings, the stipulation shall be binding on the parties and the presiding administrative law judge.

d. Exhibits.

(1) *Identification of exhibits.* Exhibits attached to a stipulation or entered in evidence which are offered by protesters shall be numbered serially, i.e., 1, 2, 3, etc.; whereas, those offered by the department shall be lettered serially, i.e., A, B, C, etc.; and those offered jointly shall be numbered and lettered, i.e., 1-A, 2-B, 3-C, etc.

(2) *Disposition of exhibits.* After an order has become final, either party desiring the return, at the party's expense, of any exhibit belonging to the party shall make application in writing to the administrative law judge within 30 days suggesting a practical manner of delivery; otherwise, exhibits may be disposed of as the administrative law judge deems advisable.

e. Official notice. The administrative law judge may take official notice of all facts of which judicial notice may be taken and of other facts within the specialized knowledge of the department. Parties shall be notified at the earliest practicable time, either before or during the hearing, or by reference in preliminary reports, preliminary decisions or otherwise, of the facts proposed to be noticed and their source, including any staff memoranda or data. The parties shall be afforded an opportunity to contest such facts prior to the issuance of the decision in the contested case proceeding unless the administrative law judge determines as a part of the record or decision that fairness to the parties does not require an opportunity to contest such facts.

f. Evidence outside the record. Except as provided by these rules, the administrative law judge shall not consider factual information or evidence in the determination of any proceeding unless the same shall have been offered and made a part of the record in the proceeding.

g. Presentation of evidence and testimony. In any hearing each party thereto shall have the right to present evidence and testimony of witnesses and to cross-examine any witness who testifies on behalf of an adverse party. Persons whose testimony has been submitted in written form, if available, shall also be subject to cross-examination by an adverse party. Opportunity shall be afforded each party for redirect examination and recross examination and to present evidence and testimony as rebuttal to evidence presented by another party, except that unduly repetitious evidence shall be excluded.

h. Offer of proof. An offer of proof may be made through the witness or by statement of counsel. The party objecting may cross-examine the witness without waiving any objection.

7.17(3) *Motions.* After commencement of contested case proceedings, appropriate motions may be filed by any party with the administrative law judge when facts requiring such motion come to the knowledge of the party. All motions shall state the relief sought and the grounds upon which the same are based.

Motions made prior to a hearing shall be in writing and a copy thereof served on all parties and attorneys of record. Such motions shall be ruled on by the administrative law judge. The administrative law judge shall rule on the motion by issuing an order. A copy of the order containing the ruling on the motion shall be mailed to the parties and authorized representatives. Motions may be made orally during the course of a hearing; however, the administrative law judge may request that it be reduced to writing and filed with the administrative law judge.

To avoid a hearing on a motion, it is advisable to secure the consent of the opposite party prior to filing the motion. If consent of the opposite party to the motion is not obtained, a hearing on the motion may be scheduled and the parties notified. The burden will be on the party filing the motion to show good cause why the motion should be granted.

The party making the motion may annex thereto such affidavits as are deemed essential to the disposition of the motion, which shall be served with the motion and to which the opposite party may reply with counter affidavits.

a. Types of motions. Types of motions include but are not limited to:

(1) Motion for continuance.

(2) Motion for dismissal.

(3) Motion for summary judgment.

(4) Motion to delete identifying details in the decision.

b. Hearing on motions. Motions relating to proceedings prior to hearing in contested case proceedings shall be heard by the department's administrative law judge. Motions relating to the contested case hearing shall be heard by the presiding administrative law judge.

c. Summary judgment procedure. Summary judgment may be obtained under the following conditions and circumstances:

(1) A party may, after a reasonable time to complete discovery, after completion of discovery, or by agreement of the parties, move with or without supporting affidavits for a summary judgment in the party's favor upon all or any part of a party's claim or defense.

(2) The motion shall be filed not less than 45 days prior to the date the case is set for hearing, unless otherwise ordered by the administrative law judge. Any party resisting the motion shall file within 30 days from the time of service of the motion a resistance; statement of disputed facts, if any; and memorandum of authorities supporting the resistance. If affidavits supporting the resistance are filed, they must be filed with the resistance. The time fixed for hearing or normal submission on the motion shall be not less than 35 days after the filing of the motion, unless another time is ordered by the administrative law judge. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

(3) Upon any motion for summary judgment pursuant to this rule, there shall be annexed to the motion a separate, short, and concise statement of the material facts as to which the moving party contends there is no genuine issue to be tried, including specific reference to those parts of the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits which support such contentions and a memorandum of authorities.

(4) Supporting and opposing affidavits shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. The administrative law judge may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, further affidavits, or oral testimony. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the party's pleading, but the party's response must set forth specific facts, by affidavits or as otherwise provided in this rule, showing that there is a genuine issue for hearing. If the party does not so respond, summary judgment, if appropriate, shall be entered against the party.

(5) If on motion under this rule judgment is not rendered upon the whole case or for all the relief asked and a hearing is necessary, the administrative law judge at the hearing of the motion, by examining the pleadings and the evidence before the administrative law judge and by interrogating counsel, shall, if practicable, ascertain what material facts exist without substantial controversy and what material facts are actually and in good faith controverted. The administrative law judge shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the hearing of the contested case the facts so specified shall be deemed established, and the hearing shall be conducted accordingly.

(6) Should it appear from the affidavits of a party opposing the motion that the party cannot for reasons stated present, by affidavit, facts essential to justify the party's opposition, the administrative law judge may refuse the application for judgment, or may order a continuance to permit affidavits to be obtained, or depositions to be taken or discovery to be completed, or may make other order.

(7) An order on summary judgment that disposes of less than the entire case is appealable to the director at the same time that the proposed order is appealable pursuant to subrule 7.17(5).

7.17(4) *Briefs and oral argument.* At any time, upon the request of any party or in the administrative law judge's discretion, the administrative law judge may require the filing of briefs on any of the issues before the administrative law judge prior to or at the time of hearing or at a subsequent time. At the hearing, the parties should be prepared to make oral arguments as to the facts and law at the conclusion of the hearing if the administrative law judge so directs.

An original copy only of all briefs shall be filed. Filed briefs shall conform to the requirements of 701—7.5(17A).

If the parties agree on a schedule for submission of briefs, the schedule shall be binding on the parties and the presiding administrative law judge except that, for good cause shown, the time may be extended upon application of a party.

7.17(5) *Orders.* At the conclusion of the hearing, the administrative law judge, in the administrative law judge's discretion, may request the parties to submit proposed findings of fact and conclusions of law. Upon the request of any party, the administrative law judge shall allow the parties an opportunity to submit proposed findings of fact and conclusions of law.

The decision in a contested case is an order which shall be in writing or stated in the record. The order shall include findings of fact prepared by the person presiding at the hearing, unless the person is unavailable, and based solely on the evidence in the record and on matters officially noticed in the record, and shall include conclusions of law. The findings of fact and conclusions of law shall be separately stated. If a party has submitted proposed findings of fact, the order shall include a ruling upon each proposed finding. Each conclusion of law shall be supported by cited authority or by a reasoned opinion. If the issue of reasonable litigation costs was held in abeyance pending the outcome of the substantive issues in the contested case and the proposed order decides substantive issues in favor of protester, the proposed order shall include a notice of time and place for a hearing on the issue of whether reasonable litigation costs shall be awarded and on the issue of amount of such award, unless the parties agree otherwise.

When a motion has been made to delete identifying details in an order on the basis of personal privacy or trade secrets, the justification for such deletion or refusal to delete shall be made by the moving party and shall appear in the order.

When the director initially presides at a hearing or considers decisions on appeal from, or review of the administrative law judge, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to, or review on motion of a second agency within the time provided by statute or rule. When an administrative law judge presides at the hearing, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to, or review on motion of, the director within 30 days of the date of the order, or 10 days, excluding Saturdays, Sundays, and legal holidays, for a revocation order pursuant to rule 701—7.24(17A). However, if the contested case proceeding involves a question of an award of reasonable litigation costs, the proposed order on the substantive issues shall not be appealable to, or reviewable by the director on the director's motion, until the issuance of a proposed order on the reasonable litigation costs. If there is no such appeal or review within 30 days or 10 days, whichever is applicable, from the date of the proposed order on reasonable litigation costs, both the proposed order on the substantive issues and the proposed order on the reasonable litigation costs become the final orders of the department for purposes of judicial review or rehearing. On an appeal from, review of or applications for rehearing concerning the administrative law judge's order, the director has all the power which the director would initially have had in making the decision, however, the director will only consider those issues or selected issues presented at the hearing before the administrative law judge or any issues of fact or law raised independently by the administrative law judge, including the propriety of and the authority for raising issues. The parties will be notified of those issues which will be considered by the director.

Orders will be issued within a reasonable time after termination of the hearing. Parties shall be promptly notified of each order by delivery to them of a copy of the order by personal service or certified mail, return receipt requested, except in the case of an order revoking a sales or use tax permit or a motor fuel license which may be delivered by ordinary mail.

A cross-appeal may be taken within the 30-day period for taking an appeal to the director of revenue or in any event within 5 days after the appeal to the director is taken. If a cross-appeal is taken from a revocation order pursuant to rule 701—7.24(17A), the cross-appeal may be taken within the 10-day period for taking an appeal to the director or in any event within 5 days after the appeal to the director is taken.

7.17(6) *Expedited cases—when applicable.* In case a protest is filed where:

1. The case is not of precedential value, and

2. The parties desire a prompt resolution of the dispute, then the department and the protester may agree to have the case designated as an expedited case.

a. Agreement. The department and the protester shall execute an agreement to have the case treated as an expedited case. In this case, discovery is waived. The provisions of this agreement shall constitute a waiver of the rights set forth in Iowa Code chapter 17A for contested case proceedings.

b. Finality of decision. A decision entered in an expedited case proceeding shall not be reviewed by the director, state board of tax review, or any other court and shall not be treated as a precedent for any other case.

c. Discontinuance of proceedings. Any time prior to a decision being rendered, the taxpayer or the department may request that expedited case proceedings be discontinued if there are reasonable grounds to believe that the issues in dispute would be of precedential value.

d. Procedure. Upon return of an executed agreement for this procedure, the department shall within 14 days file its answer to the protest. The case shall be docketed for hearing as promptly as the presiding administrative law judge can reasonably hear the matter.

7.17(7) *Burden of proof.* The burden of proof with respect to assessments or denials of refunds in contested case proceedings involving notices of assessments or refund denials issued on or after January 1, 1995, is as follows:

a. The department must carry the burden of proof by clear and convincing evidence as to the issue of fraud with intent to evade tax.

b. The burden of proof is on the department for any tax periods for which the assessment was not made within six years after the return became due, excluding any extension of time for filing such return, except where the department's assessment is the result of the final disposition of a matter between the taxpayer and the Internal Revenue Service or where the taxpayer and the department signed a waiver of the statute of limitations to assess.

c. The burden of proof is on the department as to any new matter or affirmative defense raised by the department. "New matter" means an adjustment not set forth in the computation of the tax in the assessment or refund denial, as distinguished from a new reason for the assessment or refund denial. "Affirmative defense" is one resting on facts not necessary to support the taxpayer's case.

d. In all instances where the burden of proof is not expressly placed upon the department in this subrule, the burden of proof is upon the protester.

7.17(8) *Costs.* A prevailing taxpayer in a contested case proceeding related to the determination, collection, or refund of a tax, penalty, or interest may be awarded reasonable litigation costs by the department, incurred subsequent to the issuance of the notice of assessment or refund denial on or after January 1, 1995, based upon the following:

a. The reasonable expenses of expert witnesses.

b. The reasonable costs of studies, reports, and tests.

c. The reasonable fees of independent attorneys or independent accountants retained by the taxpayer. No such award is authorized for accountants or attorneys who represent themselves or who are employees of the taxpayer.

d. An award for reasonable litigation costs shall not exceed $25,000 per case.

e. No award shall be made for any portion of the proceeding which has been unreasonably protracted by the taxpayer.

f. For purposes of this subrule, "prevailing taxpayer" means a taxpayer who establishes that the position of the department in the contested case proceeding was not substantially justified and who has substantially prevailed with respect to the amount in controversy or has substantially prevailed with respect to the most significant issue or set of issues presented. If the position of the department, in issuance of the assessment or refund denial, was not substantially justified and if the matter is resolved or conceded before the contested case proceeding is commenced, there cannot be an award for reasonable litigation costs.

g. The definition of "prevailing taxpayer" is taken from the definition of "prevailing party" in 26 U.S.C. §7430. Therefore, federal cases determining whether the Internal Revenue Service's position

was substantially justified will be considered in the determination of whether a taxpayer is entitled to an award of reasonable litigation costs to the extent that 26 U.S.C. §7430 is consistent with Iowa Code section 421.60(4).

h. The taxpayer has the burden of establishing the unreasonableness of the department's position.

i. Once a contested case has commenced, a concession by the department of its position or a settlement of the case either prior to the evidentiary hearing or any order issued does not per se either authorize an award of reasonable litigation costs or preclude such award.

j. If the department relied upon information provided or action conducted by federal, state, or local officials or law enforcement agencies with respect to the tax imposed by Iowa Code chapter 453B, an award for reasonable litigation costs shall not be made in a contested case proceeding involving the determination, collection, or refund of that tax.

k. The taxpayer who seeks an award of reasonable litigation costs must specifically request such award in the protest or it will not be considered.

l. A request for an award of reasonable litigation costs shall be held in abeyance until the concession or settlement of the contested case proceeding or the issuance of a proposed order in the contested case proceeding, unless the parties agree otherwise.

m. At the hearing held for the purpose of deciding whether an award for reasonable litigation costs should be awarded, consideration shall be given to the following points:

(1) Whether the department's position was substantially justified;

(2) Whether the protester is the prevailing taxpayer;

(3) The burden is upon protester to establish how the alleged reasonable litigation costs were incurred. This requires a detailed accounting of the nature of each cost, the amount of each cost, and to whom the cost was paid or owed;

(4) Whether alleged litigation costs are reasonable or necessary;

(5) Whether protester has met its burden of demonstrating all of these points.

This rule is intended to implement Iowa Code sections 10A.202(1)*"m,"* 17A.15(3), 421.60, 422.57(1) and 452A.68.

701—7.18(17A) Interventions. Interventions shall be governed by the Iowa rules of civil procedure.

701—7.19(17A) Record and transcript. The record in a contested case shall include:

1. All pleadings, motions and rulings;
2. All evidence received or considered and all other submissions;
3. A statement of all matters officially noticed;
4. All questions and offers of proof, objections, and rulings thereon;
5. All proposed findings and exceptions;
6. The order of the administrative law judge.

Oral hearings regarding proceedings on appeal to or considered on motion of the director which are recorded by mechanical means shall not be transcribed for the record of such appeal or review unless a party, by written notice, or the director, orally or in writing, requests such transcription. A transcription will be made only of that portion of the oral hearing relevant to the appeal or review if so requested and no objection is made by any other party to the proceeding or the director.

701—7.20(17A) Rehearing. Any party may file an application with the director for a rehearing in the contested case, stating the specific grounds therefor and the relief sought. The application must be filed within 20 days after the department has issued a final order. See subrule 7.17(5) as to when a proposed order becomes a final order. A copy of such application shall be timely mailed by the applicant to all parties in conformity with rule 701—7.21(17A). The director shall have 20 days from the filing of the application to grant or deny the rehearing. If the application is granted, a notice will be served on the parties stating the time and place of the rehearing. An application for rehearing shall be deemed denied if not granted by the director within 20 days after filing.

The application for rehearing which is filed shall contain:

1. A caption in the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____	*	APPLICATION
(state the taxpayer's name, address	*	FOR
and designate type of proceeding,	*	REHEARING
e.g., income tax refund claim)	*	DOCKET NO. _____

2. Substantially state in separate numbered paragraphs the following:

a. Clear and concise statements of the reasons for requesting a rehearing and each and every error which the party alleges to have been committed during the contested case proceedings;

b. Clear and concise statements of all relevant facts upon which the party relies;

c. Refer to any particular statute or statutes and any rule or rules involved;

d. The signature of the party or that of the party's representative, the addresses of the party or the party's representative, and the telephone number of the party or the party's representative.

No applications for rehearing shall be entertained by the department's administrative law judges.

This rule is intended to implement Iowa Code section 17A.16(2).

701—7.21(17A) Service. All papers or documents required by 701—Chapter 7 to be filed with the department, administrative law judge, with the opposing party or other person shall be served by ordinary mail unless another rule specifically refers to another method. All notices required by 701—Chapter 7 to be served on parties or persons by the department or administrative law judge shall be served by ordinary mail unless another rule specifically refers to another method.

This rule is intended to implement Iowa Code chapter 17A.

701—7.22 Reserved.

701—7.23(17A) Ex parte communications.

7.23(1) *Administrative law judges.* Iowa Code section 17A.17 provides that individuals assigned to render a proposed or final decision or to make findings of fact and conclusions of law in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact or law in that contested case, with any party, or any person with a personal interest in or engaged in prosecuting or advocating in either the case under consideration or a pending factually related case involving the same parties, except upon notice and opportunity for all parties to participate. Therefore, if the administrative law judge desires to communicate with any party or person with a personal interest in or engaged in prosecuting or advocating in either the case under consideration before the administrative law judge or a pending factually related case involving the same parties, the administrative law judge shall notify such persons or parties indicating the time and place at which all affected persons or parties may meet to discuss the matters.

7.23(2) *Parties or their representatives.* Iowa Code section 17A.17 provides further that parties or their representatives in a contested case shall not communicate, directly or indirectly, in connection with any issue of fact or law in that contested case, with individuals assigned to render a proposed or final decision or to make findings of fact and conclusions of law in that contested case, except upon notice and opportunity for all parties to participate. Therefore, if any party or their representative desires to discuss certain matters with the administrative law judge the party should notify the administrative law judge

and the opposing party of the desire to meet with the administrative law judge and the administrative law judge upon notification of the desire shall advise the parties or their representatives in writing of the time and place at which the affected persons or parties may meet to discuss any matters.

7.23(3) *Sanctions.* Any party to a contested case proceeding may file a timely and sufficient affidavit asserting personal bias of an individual participating in the making of any proposed or final decision in that case. The department shall determine the matter as part of the record in the case. When the department in these circumstances makes such a determination with respect to a department member, that determination shall be subject to de novo judicial review in any subsequent review proceeding of the case.

The recipient of a prohibited communication as provided in section 17A.17 may be required to submit the communication if written or a summary of the communication if oral for inclusion in the record of the proceeding. As sanctions for violations of any prohibited communication provided in section 17A.17 a decision may be rendered against a party who violates these rules, or for reasonable cause shown the director may censor, suspend, or revoke a privilege to practice before the department, or for reasonable cause shown after notice and opportunity to be heard, the director may censor, suspend, or dismiss any departmental personnel.

701—7.24(17A) Licenses.

7.24(1) *Denial of license, refusal to renew license.* When the department is required by constitution or statute to provide notice and an opportunity for an evidentiary hearing prior to the refusal or denial of a license, a notice, as prescribed in 7.14(17A), shall be served by the department upon the licensee or applicant. Prior to the refusal or denial of a license, the department shall give 30 days' written notice to the applicant or licensee in which to appear at a hearing to show cause why a license should not be refused or denied. In addition to the requirements of 7.14(17A), the notice shall contain a statement of facts or conduct and the provisions of law which warrant the denial of the license or the refusal to renew a license. If the licensee so desires, the licensee may file a petition as provided in 7.24(3) with the administrative law judge within the 30 days prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this chapter governing contested case proceedings shall apply.

When a licensee has made timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally determined by the department, and, in case the application is denied or the terms of the new license limited, until the last date for seeking judicial review of the department's order or a latter date fixed by order of the department or the reviewing court. See 195—subrule 20.4(1) regarding gambling license applications.

7.24(2) *Revocation of license.* The department shall not revoke, suspend, annul or withdraw any license until written notice is served by personal service or restricted certified mail pursuant to 7.14(17A) within the time prescribed by the applicable statute and the licensee whose license is to be revoked, suspended, annulled or withdrawn is given an opportunity to show at an evidentiary hearing conducted pursuant to the rules governing contested case proceedings in this chapter compliance with all lawful requirements for the retention of the license. However, in the case of the revocation, suspension, annulment, or withdrawal of a sales or use tax permit, written notice will be served pursuant to 7.14(17A) only if the permit holder requests that this be done following notification, by ordinary mail, of the director's intent to revoke, suspend, annul, or withdraw the permit. In addition to the requirements of 7.14(17A) the notice shall contain a statement of facts or conduct and the provisions of law which warrant the revocation, suspension, annulment, or withdrawal of the license. A licensee whose license may be revoked, suspended, annulled, or withdrawn may file a petition as provided in 7.24(3) with the administrative law judge prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this chapter governing contested case proceedings shall apply.

Notwithstanding the above, if the department finds that public health, safety or welfare imperatively requires emergency action, and incorporates a finding to that effect in an order to the licensee, summary

suspension of a license shall be ordered pending proceedings for revocation as provided herein. These proceedings shall be promptly instituted and determined. When a summary suspension as provided herein is ordered, a notice of the time, place and nature of the evidentiary hearing shall be attached to the order.

7.24(3) *Petition.* When a person desires to file a petition as provided in 7.24(1) and 7.24(2), the petition to be filed shall contain:

a. A caption in the following form:

BEFORE THE IOWA STATE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

	*	
IN THE MATTER OF _____		PETITION
(state taxpayer's name, address and type of license)	*	DOCKET NO. _____
		(filled in by Department)
	*	

b. Substantially state in separate numbered paragraphs the following:

(1) The full name and address of the petitioner;

(2) Refer to the type of license and the relevant statutory authority;

(3) Clear, concise and complete statements of all relevant facts showing why petitioner's license should not be revoked, refused, or denied;

(4) Whether a similar license has previously been issued to or held by petitioner or revoked and if revoked the reasons therefor;

(5) The signature of the petitioner or petitioner's representative, the address of petitioner and of petitioner's representative, and the telephone number of petitioner or petitioner's representative.

701—7.25(17A) Declaratory rulings—in general. Any oral or written advice or opinion rendered to members of the public by departmental personnel not pursuant to a petition for declaratory ruling is not binding upon the department. However, departmental personnel, including field personnel, ordinarily will discuss substantive tax issues with members of the public or their representatives prior to the receipt of a petition for a declaratory ruling, but such oral or written opinions or advice are not binding on the department. This should not be construed as preventing members of the public or their representatives from inquiring whether the department will issue a declaratory ruling on a particular question. In these cases, however, the name of the taxpayer shall be disclosed. The department will also discuss questions relating to certain procedural matters as, for example, submitting a request for a declaratory ruling or submitting a petition to initiate rule-making procedures. Members of the public may, of course, seek oral technical assistance from a departmental employee in regard to the proper preparation of a return or report required to be filed with the department. Such oral advice is advisory only and the department is not bound to recognize it in the examination of the return, report or records.

7.25(1) *Uniform rules on declaratory rulings.* The department hereby adopts, subject to the exceptions and amendments listed in subrule 7.25(2), the rules of the governor's task force on uniform rules of agency procedure relating to declaratory rulings which are printed in Volume I, pages 2 through 4, of the Iowa Administrative Code as uniform rules X.1(17A) through X.7(17A), as its rules on declaratory rulings the same as if those uniform rules were reprinted herein in full.

7.25(2) *Exceptions and amendments to uniform rules on declaratory rulings.* The following exceptions and amendments are adopted to the uniform rules on declaratory rulings.

a. Add at the end of uniform rule X.1(17A), page 3, the following item of additional information:

9. Whether the petitioner is presently under audit by the department.

b. Whenever the context requires, the term "agency" when it appears in uniform rules X.1(17A) through X.7(17A), pages 2 through 4, means the department of revenue.

c. Add at the end of uniform rule X.5(17A), page 3, the following additional reason for refusal to issue a declaratory ruling:

11. The petition requests a ruling on an issue presently under investigation or audit or in rule-making proceedings or in litigation in a contested case or court proceedings.

701—7.26(17A) Department procedure for rule making—in general. Prior to the initiation of rule-making proceedings as provided for in this rule, rules which are proposed for adoption are approved by the director. The channeling of rules varies with the circumstances. When a division determines that a rule or rules should be made on a particular subject, the subject matter of the rule or rules is prepared which is reviewed by the policy section of the technical services division and the director. After approval by the director, a draft of the rule is prepared and the rule-making proceedings are initiated.

When a petition for the promulgation, amendment, or repeal of a rule is received from an interested person, a copy of the petition is given to the appropriate section or division, the director, and the legal division for their views and comments as to the propriety of the petition. If it is determined the petition discloses sufficient justification, rule-making proceedings will be initiated.

7.26(1) *Uniform rules for procedure for rule making.* The department hereby adopts, subject to the exceptions and amendments listed in subrule 7.26(2), the rules of the governor's task force on uniform rules of agency procedure relating to rule making which are printed in Volume I, page 1 and pages 5 through 14, of the Iowa Administrative Code as uniform rules X.1(17A) through X.17(17A), as its rules for rule-making procedure the same as if these uniform rules were reprinted herein in full.

7.26(2) *Exceptions and amendments to uniform rules on procedure for rule making.* The following exceptions and amendments are adopted to the uniform rules for rule-making procedure:

a. Whenever the context requires, the term "agency" when it appears in the uniform rules herein adopted means the department of revenue.

b. Inquiries concerning the status of a petition for rule making provided for in uniform rule X.3(17A), page 1 of the uniform rules, may be made to the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319.

c. The subscription price for copies of future Notices of Intended Action for subscribers is fixed for a one-year basis as provided for in uniform rule X.4(3), page 6 of the uniform rules.

d. The Office of the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319, is designated as the office where interested persons may submit argument, data and views on proposed rules as provided for in uniform subrule X.5(1), page 6 of the uniform rules.

e. The Office of the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319, is designated as the office for registering small businesses or organizations of small business for the small business impact list provided for in uniform subrule X.6(3), page 8 of the uniform rules.

f. There are no known categories of rules exempt from the usual public notice and participation requirements as authorized by uniform subrule X.10(2), page 11 of the uniform rules.

g. The Office of the Deputy Director of Revenue, Hoover State Office Building, Des Moines, Iowa 50319, is the designated office for delivery of a request for a concise statement of reason, provided for in subrule X.11(1), page 11 of the uniform rules.

These rules are intended to implement Iowa Code sections 17A.22 and 421.14 and to implement the uniform rules on agency procedure as accepted and approved by the governor.

701—7.27(9C,91C) Procedure for nonlocal business entity bond forfeitures. Upon the failure of a transient merchant or an out-of-state contractor to pay any taxes payable, the amount of bond posted with the secretary of state by the transient merchant or out-of-state contractor necessary to pay the tax shall be forfeited. The following subrules of this rule shall govern the procedure for that forfeiture.

7.27(1) *Definitions.*

a. "Nonlocal business entity" is either an out-of-state contractor or a transient merchant as those terms are defined in paragraphs *"b"* and *"f."*

b. "Out-of-state contractor" means a general contractor, subcontractor, architect, engineer, or other person who contracts to perform in this state construction or installation of structures or other buildings or any other work covered by Iowa Code chapter 103A and whose principal place of business is outside Iowa.

c. "Taxes payable by a transient merchant" refers to all taxes administered by the department, and penalties, interest, and fees which the department has previously determined to be due by assessment or due as a result of an appeal from an assessment.

d. "Taxes payable by an out-of-state contractor" means tax, penalty, interest, and fees which the department, another state agency, or a subdivision of the state, has determined to be due by assessment or due as a result of an appeal from an assessment. The tax assessed must accrue as the result of a contract to perform work covered by Iowa Code chapter 103A.

e. "Taxes payable" means any amount referred to in subparagraphs *"c"* and *"d"* above.

f. "Transient merchant" shall be defined, for the purposes of this rule, as that phrase is defined in Iowa Code section 9C.1.

7.27(2) *Increases in existing bonds.* If an out-of-state contractor has on file with the secretary of state a bond for any particular contract and for that particular contract the contractor has tax due and owing but unpaid and this tax is greater than the amount of the bond, the department shall require the out-of-state contractor to increase the bond on file with the secretary of state in an amount sufficient to pay tax liabilities which will become due and owing under the contract in the future.

7.27(3) *Responsibility for notification.* Concerning taxes payable by an out-of-state contractor, which are not administered by the department of revenue, it shall be the duty of the department or subdivision of Iowa state government to which the taxes are owed to notify the department of revenue of the taxes payable by the out-of-state contractor in order to institute bond forfeiture proceedings or an increase in the amount of the bond which the out-of-state contractor must post.

7.27(4) *Initial notification.* After it is determined that a bond ought to be forfeited, notice of this intent shall be sent to a nonlocal business entity and its surety of record, if any. Notice sent to a nonlocal business entity or its surety shall be sent to the last known address as reflected in the records of the secretary of state. The notice sent to an out-of-state contractor shall also be mailed to the contractor's registered agent for service of process, if any, within Iowa. This notice may be sent by ordinary mail. The notice shall state the intent to demand forfeiture of the nonlocal business entity's bond, the amount of bond to be forfeited, the nature of the taxes alleged to be payable, the period for which these taxes are due, and the department or subdivision of Iowa to which the taxes are payable. The notice shall also state the statutory authority for the forfeiture and the right to a hearing upon timely application.

7.27(5) *Protest to bond forfeiture.* The application of a nonlocal business entity for a hearing shall be written and substantially in the form set out for protests to other departmental action in 701—7.8(17A). The caption of the application shall be basically in the form set out in subrule 7.8(1) except the type of proceeding shall be designated as a bond forfeiture collection. The body of the application for hearing must substantially resemble the body of the protest described in subrule 7.8(2). However, referring to subrule 7.8(2), paragraph *"a,"* the nonlocal business entity shall state the date of the notice described in subrule 7.27(4). With regard to subrule 7.8(2), paragraph *"c,"* in the case of a tax payable which is not administered by the department, the errors alleged may be errors on the part of other departments or subdivisions of the state of Iowa. The application for hearing shall be filed with the department's administrative law judge in the manner described in 701—7.8(17A). The docketing of an application for hearing shall follow the procedure for the docketing of a protest under that rule.

7.27(6) *Prehearing, hearing and rehearing procedures.* The following Chapter 7 rules are applicable to preliminary and contested case proceedings under this rule: 701—7.3(17A) to 701—7.7(17A), 701—7.9(17A) to 701—7.13(17A), 701—7.15(17A) to 701—7.21(17A), 701—7.23(17A), and subrule 7.14(2). The strictures of subrule 7.14(1) are not applicable to contested cases arising under this rule.

7.27(7) *Sureties and state departments other than revenue.* A surety shall not have standing to contest the amount of any tax payable.

If there exist taxes payable by an out-of-state contractor and these taxes are payable to a department or subdivision of state government other than the department of revenue, that department or subdivision

shall be the real party in interest to any proceeding conducted under this rule, and it shall be the responsibility of that department or subdivision to provide its own representation and otherwise bear the expenses of representation.

Rules 7.1(17A) to 7.27(9C,91C) are intended to implement Iowa Code sections 9C.4, 17A.1(2), 17A.2(2), 17A.11, 91C.7, and 421.8A.

701—7.28 and **7.29** Reserved.

701—7.30(421) Definitions which apply to rules 701—7.31(421) to 701—7.35(421).

7.30(1) The term *"entity"* means any taxpayer other than an individual or sole proprietorship.

7.30(2) The term *"last-known address"* does not necessarily mean the taxpayer's actual address but instead means the last address that the taxpayer makes known to the department by tax type. Thus, for instance, receipt by the department of a taxpayer's change of address from a third person not authorized to act on behalf of the taxpayer (e.g., an employer who had filed a form W-2 showing a new taxpayer address) is not notice to the department of a change of address of the taxpayer. However, the filing by the taxpayer of a tax return for a year subsequent to the year for which a notice is required would be notification to the department of a change of address, provided a reasonable amount of time is allowed to process and transfer such information to the department's central computer system. The meaning of this phrase is important, and taxpayers should be aware of their need to update their address with the department in order to receive refunds of tax and notices of assessments and denial of a claim for refund. When such a notice is sent to a "taxpayer's last-known address" the notice is legally effective even if the taxpayer never receives it.

7.30(3) The term *"taxpayer interview"* means any in-person contact from and after January 1, 1995, between an employee of the department and a taxpayer or a taxpayer's representative which has been initiated by a department employee.

7.30(4) The term *"taxpayer representative"* or *"authorized taxpayer representative"* means an individual authorized to practice before the department under rule 701—7.6(17A); an individual who has been named as an authorized representative on a fiduciary return of income form filed under Iowa Code section 422.14, or a tax return filed under Iowa Code chapter 450, "Inheritance Tax," 450A, "Generation Skipping Tax," or 451, "Estate Tax"; or for proceedings before the department any other individual the taxpayer designates who is named on a valid power of attorney if appearing on behalf of another.

This rule is intended to implement Iowa Code section 421.60.

701—7.31(421) Abatement of unpaid tax. For assessment notices issued on or after January 1, 1995, if the statutory period for appeal has expired, the director may abate any portion of unpaid tax, penalties or interest which the director determines is erroneous, illegal, or excessive. The authority of the director to compromise and settle doubtful and disputed claims for taxes or tax refunds or tax liability of doubtful collectability is not covered by this rule.

This authority exists pursuant to Iowa Code section 421.5.

7.31(1) *Assessments qualifying for abatement.* To be subject to an abatement, an assessment or a portion of an assessment for which abatement is sought must not have been paid and must have exceeded the amount due as provided by the Iowa Code and the administrative rules issued by the department interpreting the Iowa Code. If a taxpayer fails to timely appeal an assessment that is based on the Iowa Code or the department's administrative rules interpreting the Iowa Code within the statutory period, then the taxpayer cannot request an abatement of the assessment, or a portion thereof.

7.31(2) *Procedures for requesting abatement.* The taxpayer must make a written request to the director for abatement of that portion of the assessment that is alleged to be erroneous, illegal, or excessive. A request for abatement which is filed must contain:

a. The taxpayer's name and address, social security number, federal identification number, or any permit number issued by the department;

b. A statement on the type of proceeding, e.g., individual income tax, request for abatement; and

c. The following information:

(1) The type of tax, the taxable period or periods involved, and the amount thereof that was excessive or erroneously or illegally assessed;

(2) Clear and concise statements of each and every error which the taxpayer alleges to have been committed by the director in the notice of assessment and which causes the assessment to be erroneous, illegal, or excessive. Each assignment of error must be separately numbered;

(3) Clear and concise statements of all relevant facts upon which the taxpayer relies (documents verifying the correct amount of tax liability must be attached to this request);

(4) Refer to any particular statute or statutes and any rule or rules involved, if known;

(5) The signature of the taxpayer or that of the taxpayer's representative and the addresses of the taxpayer and the taxpayer's representative;

(6) Description of records or documents which were not available or were not presented to department personnel prior to the filing of this request, if any; and provide copies of any records or documents that were not previously presented to the department; and

(7) Any other matters deemed relevant and not covered in the above paragraphs.

This rule is intended to implement Iowa Code section 421.60.

701—7.32(421) Time and place of taxpayer interviews. The time and place of taxpayer interviews are to be fixed by an employee of the department and employees are to endeavor to schedule a time and place that are reasonable under the circumstances.

7.32(1) *Time of taxpayer interviews.* The department will schedule the day(s) for a taxpayer interview during a normally scheduled workday(s) of the department, during the department's normal business hours. The department will schedule taxpayer interviews throughout the year without regard to seasonal fluctuations in the business of particular taxpayers or their representatives. The department will, however, work with taxpayers or their representatives to try to minimize any adverse effects in scheduling the date and time of a taxpayer interview.

7.32(2) *Type of taxpayer interview.* The department will determine whether a taxpayer interview will be an office interview (i.e., an interview conducted at a department office) or a field interview (i.e., an interview conducted at the taxpayer's place of business or residence, or some other location that is not a department office) based on which form of interview will be more conducive to effective and efficient tax administration.

The department will grant a request to hold an office interview at a location other than a department office in case of a clear need, such as when it would be unreasonably difficult for the taxpayer to travel to a department office because of the taxpayer's advanced age or infirm physical condition, or when the taxpayer's books, records, and source documents are too cumbersome for the taxpayer to bring to a department office.

7.32(3) *Place of taxpayer interview.* The department will make an initial determination of the place for an interview, including the department region office to which an interview will be assigned, based on the address shown on the return for the tax period to be examined. Requests by taxpayers to transfer the place of interview will be resolved on a case-by-case basis, using the criteria set forth in paragraph *"c"* of this subrule.

a. Office taxpayer interviews. An office interview of an individual or sole proprietorship generally is based on the residence of the individual taxpayer. An office interview of a taxpayer which is an entity generally is based on the location where the taxpayer entity's original books, records, and source documents are maintained.

b. Field taxpayer interviews. A field interview generally will take place at the location where the taxpayer's original books, records, and source documents pertinent to the interview are maintained. In the case of a sole proprietorship or taxpayer entity, this usually will be the taxpayer's principal place of business. If an interview is scheduled by the department at the taxpayer's place of business, which is a small business and the taxpayer represents to the department in writing that conducting the interview at the place of business would essentially require the business to close or would unduly disrupt business operations, the department upon verification will change the place of interview.

c. Requests by taxpayers to change place of interview. The department will consider, on a case-by-case basis, written requests by taxpayers or their representatives to change the place that the department has set for an interview. In considering these requests, the department will take into account the following factors:

(1) The location of the taxpayer's current residence;

(2) The location of the taxpayer's current principal place of business;

(3) The location where the taxpayer's books, records, and source documents are maintained;

(4) The location at which the department can perform the interview most efficiently;

(5) The department resources available at the location to which the taxpayer has requested a transfer; and

(6) Other factors that indicate that conducting the interview at a particular location could pose undue inconvenience to the taxpayer.

A request by a taxpayer to transfer the place of interview generally will be granted under the following circumstances:

1. If the current residence of the taxpayer in the case of an individual or sole proprietorship, or the location where the taxpayer's books, records, and source documents are maintained, in case of a taxpayer entity, is closer to a different department office than the office where the interview has been scheduled, the department normally will agree to transfer the interview to the closer department office.

2. If a taxpayer does not reside at the residence where an interview has been scheduled, the department will agree to transfer the examination to the taxpayer's current residence.

3. If, in the case of an individual, a sole proprietorship, or a taxpayer entity, the taxpayer's books, records, and source documents are maintained at a location other than the location where the interview has been scheduled, the department will agree to transfer the interview to the location where the taxpayer's books, records, and source documents are maintained.

4. The location of the place of business of a taxpayer's representative generally will not be considered in determining the place for an interview. However, the department in its sole discretion may determine, based on the factors described in paragraph *"c"* of this subrule, to transfer the place of interview to the representative's office.

5. If any applicable period of limitations of assessment and collection provided in the Iowa Code will expire within 13 months from the date of a taxpayer's request to transfer the place of interview, the department may require, as a condition to the transfer, that the taxpayer agree in writing to extend the limitations period up to one year.

6. The department is not required to transfer an interview to an office that does not have adequate resources to conduct the interview.

7. Notwithstanding any other provision of this rule, employees of the department may decline to conduct an interview at a particular location if it appears that the possibility of physical danger may exist at that location. In these circumstances, the department may transfer an interview to a department office and take any other steps reasonably necessary to protect its employees.

8. Nothing in this rule shall be interpreted as precluding the department from initiating the transfer of an interview if the transfer would promote the effective and efficient conduct of the interview. Should a taxpayer request that such a transfer not be made, the department will consider the request according to the principles and criteria set forth in paragraph *"c"* of this subrule.

9. Regardless of where an examination takes place, the department may visit the taxpayer's place of business or residence to establish facts that can only be established by direct visit, such as inventory or asset verification. The department generally will visit for these purposes on a normal workday of the department during the department's normal business hours.

7.32(4) *Audio recordings of taxpayer interviews.*

a. A taxpayer is permitted, upon advance notice to the department, to make an audio recording of any interview of the taxpayer by the department relating to the determination or collection of any tax. The recording of the interview is at the taxpayer's own expense and must be with the taxpayer's own equipment.

Requests by taxpayers to make audio recordings must be addressed to the department employee who is conducting the interview and must be received by no later than ten calendar days before the interview. If ten calendar days' advance notice is not given, the department may, in its discretion, conduct the interview as scheduled or set a new date.

The department employee conducting the interview will approve the request to record the interview if:

(1) The taxpayer (or representative) supplies the recording equipment;

(2) The department may produce its own recording of the proceedings;

(3) The recording takes place in a suitable location; and

(4) All participants in the proceedings other than department personnel consent to the making of the audio recording, and all participants identify themselves and their role in the proceedings.

b. A department employee is also authorized to record any taxpayer interview, if the taxpayer receives prior notice of the recording and is provided with a transcript or a copy of the recording upon the taxpayer's request.

Requests by taxpayers (or their representatives) for a copy or transcript of an audio recording produced by the department must be addressed to the employee conducting the interview and must be received by the department no later than 30 calendar days after the date of the recording. Taxpayers must pay the costs of duplication or transcription.

c. At the beginning of the recording of an interview the department employee conducting the interview must state the employee's name, the date, the time, the place, and the purpose of the interview.

At the end of the interview, the department employee will state that the interview has been completed and that the recording has ended.

d. When written records are presented or discussed during the interview being recorded, they must be described in sufficient detail to make the audio recording a meaningful record when matched with the other documentation contained in the case file.

This rule is intended to implement Iowa Code section 421.60.

701—7.33(421) Mailing to the last-known address. If the department fails to mail a notice of assessment to the taxpayer's last-known address or fails to personally deliver the notice to the taxpayer, on or after January 1, 1995, interest is waived for the month the failure occurs through the month of correct mailing or personal delivery.

In addition, on or after January 1, 1995, if the department fails to mail a notice of assessment or denial of a claim for refund to the taxpayer's last-known address or fails to personally deliver the notice to a taxpayer and, if applicable, to the taxpayer's authorized representative, the time period to appeal the notice of assessment or a denial of a claim for refund is suspended until the notice or claim denial is correctly mailed or personally delivered or for a period not to exceed one year, whichever is the lesser period.

Collection activities, except when a jeopardy situation exists, shall be suspended and the statute of limitations for assessment and collection of the tax shall be tolled during the period in which interest is waived.

7.33(1) The department will make the determination of the taxpayer's last-known address on a tax-type-by-tax-type basis. However, a notice of assessment or refund claim denial will be considered to be mailed to the last-known address if it is mailed to an address used for another tax type.

A notice of assessment mailed to one of two addresses used by a taxpayer was sufficient. L. P. Marvin, Sr., 40TC 982.Dec. 26, 313; U.C. Massengale, (CA-4) 69-1 USTC paragraph 9310, 408 F.2d 1372.

7.33(2) The last-known address is the address used on the most recent filed and processed return. The following principles, established by case law, for the Internal Revenue Service (IRS) also will be applied in determining the taxpayer's last-known address for purposes of this rule.

Although the taxpayer filed a tax return showing a new address, the IRS had not processed the return sufficiently for the new address to be available by computer to the IRS agent who sent the notice of deficiency. Before a change of address is considered available, a reasonable amount of time must

be allowed to process and transfer information to the IRS' central computer system. *Diane Williams v. Commissioner of Internal Revenue*, U.S. Court of Appeals, 9th Circuit; 935 F. 2d 1066. Affirming the Tax Court, 57 TCM 1357, Dec. 45, 953(M), TAC Memo. 1989-439.

If the department knows the taxpayer has moved but does not know the new mailing address, the prior mailing address is the proper place to send a deficiency notice. M. Kaestner, CDC 71-2 USTC paragraph 9512, 329 F. Supp. 1082. Aff'd per curiam, (CA-9) 73-1 USTC paragraph 9266, 473 F. 2d 1294. H. Kohn, DC Mass, 85-2 USTC paragraph 9725.

Knowledge acquired by a collection agent regarding the taxpayer's address in an unrelated investigation was not required to be imputed to the examination division responsible for mailing a notice of deficiency. R. H. Wise, DC Mont., 88-1 USTC paragraph 9365, 688 F. Supp. 1164.

However, information acquired by the department in a related investigation of the taxpayer is binding upon the department, e.g., where the taxpayer files a power of attorney showing a change of address.

7.33(3) Procedures for notifying the department of a change in taxpayer's address. The department generally will use the address on the most recent filed and properly processed return by tax type as the address of record for all notices of assessment and denial of claims for refund. If a taxpayer no longer wishes the address of record to be the address on the most recently filed return, the taxpayer must give clear and concise written notification of a change in address to the department. Notifications of a change in address should be addressed to: Changes in Name or Address, Iowa Department of Revenue, P.O. Box 10413, Des Moines, Iowa 50306.

If after a joint return or married filing separately on a combined return is filed either taxpayer establishes a separate residence, each taxpayer should send clear and concise written notification of a current address to the department.

If a department employee contacts a taxpayer in connection with the filing of a return or an adjustment to a taxpayer's return, the taxpayer may provide clear and concise written notification of a change of address to the department employee who initiated the contact.

A taxpayer should notify the U.S. Postal Service facility serving the taxpayer's old address of the taxpayer's new address in order that mail from the department can be forwarded to the new address. However, notification to the U.S. Postal Service does not constitute the clear and concise written notification that is required to change a taxpayer's address of record with the department.

This rule is intended to implement Iowa Code section 421.60.

701—7.34(421) Power of attorney. No attorney, accountant, or other representative will be recognized as representing any taxpayer in regard to any claim, appeal, or other matter relating to the tax liability of such taxpayer in any hearing before or conference with the department, or any member or agent thereof, unless there is first filed with the department a written authorization.

7.34(1) A power of attorney is required by the department when the taxpayer wishes to authorize an individual to perform one or more of the following acts on behalf of the taxpayer:

a. To receive copies of any notices or documents sent by the department, its representatives or its attorneys.

b. To receive, but not to endorse and collect, checks in payment of any refund of Iowa taxes, penalties, or interest.

c. To execute waivers (including offers of waivers) of restrictions on assessment or collection of deficiencies in tax and waivers of notice of disallowance of a claim for credit or refund.

d. To execute consents extending the statutory period for assessment or collection of taxes.

e. To fully represent the taxpayer(s) in any hearing, determination, final or otherwise, or appeal.

f. To enter into any compromise with the director of revenue's office.

g. To execute any release from liability required by the department of revenue prerequisite to divulging otherwise confidential information concerning taxpayer(s).

h. Other acts as stipulated by the taxpayer.

7.34(2) A power of attorney or any supplemental notification intended to be utilized as a power of attorney must contain the following information to be valid:

a. Name and address of the taxpayer;

b. Identification number of the taxpayer (i.e., social security number, federal identification number, or any state-issued tax identification number relative to matters covered by the power of attorney);

c. Name, mailing address, and PTIN (preparer's tax identification number), FEIN (federal employer identification number) or SSN (social security number) of the representative;

d. Description of the matter(s) for which representation is authorized which, if applicable, must include:

(1) The type of tax(es) involved;

(2) The specific year(s) or period(s) involved; and

(3) In estate matters, decedent's date of death; and

e. A clear expression of the taxpayer's intention concerning the scope of authority granted to the recognized representative(s) as provided in 7.34(1).

7.34(3) A power of attorney may not be used for tax periods that end more than three years after the date on which the power of attorney is received by the department. A power of attorney may concern an unlimited number of tax periods which have ended prior to the date on which the power of attorney is received by the department; however, each tax period must be separately stated.

7.34(4) The individual who must execute a power of attorney depends on the type of taxpayer involved as follows:

a. Individual taxpayer. In matters involving an individual taxpayer, a power of attorney must be signed by the individual.

b. Husband and wife. In matters involving a joint return or married taxpayers who have elected to file separately on a combined return in which both husband and wife are to be represented by the same representative(s), the power of attorney must be executed by both husband and wife.

In any matters concerning a joint return or married taxpayers who have elected to file separately on a combined return in which both husband and wife are not to be represented by the same representatives, the power of attorney must be executed by the spouse who is to be represented. However, the recognized representative of such spouse cannot perform any act with respect to a tax matter that the spouse represented cannot perform alone.

c. Corporation. In the case of a corporation, a power of attorney must be executed by an officer of the corporation having authority to legally bind the corporation, who must certify that the officer has such authority.

d. Association. In the case of an association, a power of attorney must be executed by an officer of the association having authority to legally bind the association, who must certify that the officer has such authority.

e. Partnership. In the case of a partnership, a power of attorney must be executed by all partners, or if executed in the name of the partnership, by the partner or partners duly authorized to act for the partnership, who must certify that the partner(s) has such authority.

7.34(5) A power of attorney is not needed for individuals who have been named as an authorized representative on a fiduciary return of income filed under Iowa Code section 422.14 or a tax return filed under Iowa Code chapter 450, 450A or 451.

7.34(6) A new power of attorney for a particular tax type(s) and tax period(s) revokes a prior power of attorney for that tax type(s) and tax period(s), unless the taxpayer has indicated on the power of attorney form that a prior power of attorney is to remain in effect. For a previously designated representative to remain as the taxpayer's representative when a subsequent power of attorney form is filed, a taxpayer must attach a copy of the previously submitted power of attorney form which designates the representative that the taxpayer wishes to retain. To revoke a designated power of attorney without appointing a new power of attorney, see 7.34(7).

EXAMPLE A. A taxpayer executes a power of attorney for the taxpayer's accountant to represent the taxpayer during an audit of the taxpayer's books and records. After the department issues a notice of assessment, the taxpayer wishes to have the taxpayer's attorney-at-law as an authorized representative in addition to the taxpayer's accountant. The taxpayer may use one of two options to designate the accountant and the attorney-at-law as the taxpayer's representatives: (1) the taxpayer may complete and

submit to the department a new power of attorney, Form IA2848 or federal Form 2848, designating both the accountant and the attorney-at-law as the taxpayer's authorized representatives. By submitting a new power of attorney form, the prior power of attorney designations are revoked, leaving only the subsequent new power of attorney form effective; or (2) the taxpayer may properly complete a new power of attorney form by including the designated attorney-at-law's name, address, PTIN, FEIN or SSN, tax type(s) and tax period(s) on the first page and checking the appropriate box on page 2 of Form IA2848 or page 2 of federal Form 2848. In addition, to retain the accountant as the taxpayer's representative, the taxpayer must also attach to the new completed power of attorney form a copy of the previously submitted power of attorney form designating the accountant as the taxpayer's representative.

EXAMPLE B. Same factual scenario as in Example A applies; however, the taxpayer seeks to use power of attorney Form IA14-101 (a form that preceded the current Form IA2848). In this situation, the taxpayer must attach a statement to the completed Form IA14-101. The statement must state that the previously designated accountant is to be retained and the attorney-at-law is to be added. Such notification must also include the names, PTIN, SSN or FEIN of all the parties, addresses, tax types(s) and tax period(s) of representation.

EXAMPLE C. A taxpayer wishes to designate an additional power of attorney and retain a prior power of attorney. However, the taxpayer does not wish to utilize an IA2848 or federal 2848 form. In this situation, the taxpayer must send written notification to the department designating the new power of attorney's name, address, PTIN, SSN or FEIN, the tax type(s), the tax period(s) of representation and the name, address, and PTIN, SSN or FEIN of the previously designated power of attorney that the taxpayer seeks to retain for that tax period.

In each of the foregoing examples, the original power of attorney will continue to automatically receive the notices concerning the specified tax matter, unless such authority is explicitly revoked by the taxpayer. Also see subrule 7.34(13) regarding notices.

7.34(7) A taxpayer may revoke a power of attorney without authorizing a new representative by filing a statement of revocation with the department. The statement of revocation must indicate that the authority of the previous power of attorney is revoked and must be signed by the taxpayer. Also, the name and address of each representative whose authority is revoked must be listed (or a copy of the power of attorney must be attached).

7.34(8) A representative may withdraw from representation in a matter in which a power of attorney has been filed by filing a statement with the department. The statement must be signed by the representative and must identify the name and address of the taxpayer(s) and the matter(s) from which the representative is withdrawing.

7.34(9) A properly completed Iowa power of attorney, Form IA14-101 or IA2848, or properly designated federal form as described in this subrule, satisfies the requirements of this rule.

In addition to the Iowa power of attorney, Form IA2848 or IA14-101, the department can accept Internal Revenue Service Form 2848, if references to the "Internal Revenue Service" are crossed out and "Iowa Department of Revenue" is inserted in lieu thereof, as long as such a form contains specific designation by the taxpayer for the state-related taxes at issue. Designation must include, but is not limited to, name, address, PTIN, SSN or FEIN of the representative, the tax type(s) and tax period(s). In addition, the department will accept any other document which satisfies the requirements of this rule.

7.34(10) The department will not recognize as a valid power of attorney a power of attorney form attached to a tax return filed with the department except in the instance of a form attached to a fiduciary return of income form, inheritance tax return, generation skipping tax return, or estate tax return.

7.34(11) The department will accept either the original, an electronically scanned and transmitted power of attorney form, or a copy of a power of attorney. A copy of a power of attorney received by facsimile transmission (fax) will be accepted. All copies, facsimiles and electronically scanned and transmitted power of attorney forms must include a valid signature of the taxpayer to be represented.

7.34(12) If an individual desires to represent a taxpayer through correspondence with the department, the individual must submit a power of attorney even though no personal appearance is contemplated.

7.34(13) Any notice or other written communication (or copy thereof) required or permitted to be given to the taxpayer in any matter before the department must be given to the taxpayer and, unless

restricted by the taxpayer, to the taxpayer's first designated power of attorney who is representing the taxpayer for the tax type(s) and tax period(s) contained in the notice. Due to limitations of the department's automated systems, it is the general practice of the department to limit distribution of copies of documents by the department to the taxpayer's first designated power of attorney. Determination of the first designated power of attorney will be based on the earliest execution date of the power of attorney and the first name designated on a power of attorney form listing more than one designated representative.

7.34(14) Information from power of attorney forms, including the representative's PTIN, SSN or FEIN, is utilized by department personnel to:

a. Determine whether a representative is authorized to receive or inspect confidential tax information;

b. Determine whether the representative is authorized to perform the acts set forth in subrule 7.34(1);

c. Send copies of computer-generated notices and communications to the representative as authorized by the taxpayer; and

d. Ensure that the taxpayer's representative receives all notices and communications authorized by the taxpayer, but notices and communications are not sent to a representative with the same or similar name.

7.34(15) Procedure for waiver. Any person who believes that the application of this rule would result in hardship or injustice to that person may petition the department for a waiver in the manner set out in Section II of the governor's Executive Order Number 11, issued September 13, 1999, until superceded by a uniform departmental waiver rule.

This rule is intended to implement Iowa Code section 421.60.

701—7.35(421) Taxpayer designation of tax type and period to which voluntary payments are to be applied.

7.35(1) A taxpayer may designate in separate written instructions accompanying the payment the type of tax and tax periods to which any voluntary payment is to be applied. The taxpayer may not designate the application of payments which are the result of enforced collection.

7.35(2) Enforced collection includes, but is not limited to garnishment of wages, bank accounts, or payments due the taxpayer, or seizure of assets.

This rule is intended to implement Iowa Code section 421.60.

DIVISION II
INFORMAL, FORMAL, ADMINISTRATIVE AND JUDICIAL REVIEW PROCEDURES
APPLICABLE TO CONTESTED CASES AND OTHER PROCEEDINGS
COMMENCED ON OR AFTER JULY 1, 1999

701—7.36(421,17A) Applicability and scope of rules. Effective July 1, 1999, the rules contained in this division pertain to practice and procedure and are designed to implement the requirements of the Act, and aid in the effective and efficient administration and enforcement of the tax laws of this state and other activities of the department. These rules shall govern the practice, procedure and conduct of the informal proceedings, contested case proceedings, licensing, rule making, and declaratory orders involving taxation and other areas within the department's jurisdiction which includes the following:

1. Sales tax—Iowa Code sections 422.42 to 422.59;
2. Use tax—Iowa Code chapter 423;
3. Individual and fiduciary income tax—Iowa Code sections 422.4 to 422.31 and 422.110 to 422.112;
4. Franchise tax—Iowa Code sections 422.60 to 422.66;
5. Corporate income tax—Iowa Code sections 422.32 to 422.41 and 422.110 to 422.112;
6. Withholding tax—Iowa Code sections 422.16 and 422.17;
7. Estimated tax—Iowa Code sections 422.16, 422.17 and 422.85 to 422.92;
8. Motor fuel tax—Iowa Code chapter 452A;

9. Property tax—Iowa Code chapters 421, 425, 426A, 427, 427A, 428, 428A and 433 to 441;
10. Cigarette and tobacco tax—Iowa Code chapters 421B and 453A;
11. Inheritance, generation skipping transfer, and estate tax—Iowa Code chapters 450, 450A, 450B and 451;
12. Local option taxes—Iowa Code chapter 422B;
13. Hotel and motel tax—Iowa Code chapter 422A;
14. Drug excise tax—Iowa Code chapter 453B;
15. Automobile rental excise tax—Iowa Code chapter 422C;
16. Environmental protection charge—Iowa Code chapter 424;
17. Replacement taxes—Iowa Code chapter 437A;
18. Statewide property tax—Iowa Code chapter 437A;
19. Set-off procedures—Iowa Code section 421.17(29);
20. Other taxes and activities as may be assigned to the department from time to time; and
21. The Taxpayer's Bill of Rights—Iowa Code section 421.60.

As the purpose of these rules is to facilitate business and advance justice, any rule contained herein, pursuant to statutory authority, may be suspended or waived by the department to prevent undue hardship in any particular instance or to prevent surprise or injustice.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.37(421,17A) Definitions. These definitions apply to the rules contained in Division II, unless the text otherwise states to the contrary:

"Act" means the Iowa administrative procedure Act.

"Affiliate or subsidiary of an entity dominant in its field of operation" means an entity which is at least 20 percent owned by an entity that is dominant in its field of operation, or by a partner, officer, director, majority stockholder or the equivalent, of an entity dominant in that field of operation.

"Agency" means each board, commission, department, officer, or other administrative office or unit of the state.

"Contested case" means a proceeding, including licensing, in which the legal rights, duties or privileges of a party are required by constitution or statute to be determined by an agency after an opportunity for an evidentiary hearing. This term also includes any matter defined as a no factual dispute contested case under 1998 Iowa Acts, chapter 1202, section 14.

"Declaratory order" is an order issued pursuant to 1998 Iowa Acts, chapter 1202, section 13.

"Department" means the Iowa department of revenue.

"Department of inspections and appeals" means the state department created by Iowa Code chapter 10A.

"Director" means the director of the department or the director's authorized representative.

"Division of administrative hearings" means the division of the department of inspections and appeals responsible for holding contested case proceedings pursuant to Iowa Code chapter 10A.

"Dominant in its field of operation" means having more than 20 full-time equivalent positions and more than $1 million in annual gross revenues.

"Intervene" means to file a petition with the department requesting that the petitioner be allowed to intervene in the processing of a declaratory order currently under the department's consideration.

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

"License" means the whole or a part of any permit, certificate, approval, registration, charter, or similar form of permission required by statute.

"Licensing" means the department process respecting the grant, denial, renewal, revocation, suspension, annulment, withdrawal, or amendment of a license.

"Motion" has the same meaning as the term is defined in Iowa R. Civ. P. 1.431.

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

"Person" means any individual; estate; trust; fiduciary; partnership, including limited liability partnership; corporation, including limited liability corporation; association; governmental subdivision; or public or private organization of any character or any other person covered by the Act other than an agency.

"Petition" means application for declaratory order, request to intervene in a declaratory order under consideration, application for initiation of proceedings to adopt, amend or repeal a rule or document filed in licensing.

"Pleadings" means protest, answer, reply or other similar document filed in a contested case proceeding, including contested cases involving no factual dispute.

"Presiding officer" means the person designated to preside over a proceeding involving the department. A presiding officer of a contested case involving the department will be either the director or a qualified administrative law judge appointed, pursuant to Iowa Code chapter 17A, by the division of administrative hearings established pursuant to 1998 Iowa Acts, chapter 1202, section 3. In cases in which the department is not a party, at the director's discretion, the presiding officer may be the director or the director's designee. A presiding officer of an administrative appeal is the director of the department.

"Proceeding" means informal, formal and contested case proceedings.

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

"Protester" means any person entitled to file a protest which can culminate in a contested case proceeding.

"Provision of law" means the whole or part of the Constitution of the United States of America or the Constitution of the State of Iowa, or of any federal or state statute, court rule, executive order of the governor, or rule of the department.

"Review unit" means the unit composed of department employees designated by the director and the attorney general's staff who have been assigned by the director to review protests filed by taxpayers.

"Rule" means a statement by the department of general applicability that implements, interprets, or prescribes law or policy, or that describes the organization, procedure, or practice requirements of the department. Notwithstanding any other statute, the term includes an executive order or directive of the governor which creates an agency or establishes a program or which transfers a program between agencies established by statute or rule. The term includes the amendment or repeal of an existing rule, but does not include the excluded items set forth in Iowa Code section 17A.2(10).

"Small business" means any entity including, but not limited to, an individual, partnership, corporation, joint venture, association, or cooperative. A "small business" is not an affiliate of an entity dominant in its field or operation. A small business has either 20 or fewer full-time equivalent positions or less than $1 million in annual gross revenues in the preceding fiscal year.

Unless otherwise specifically stated, the terms used in these rules promulgated by the department shall have the meanings defined by the Act.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code section 421.14.

701—7.38(421,17A) Applicability of rules set forth in Division I of Chapter 7. Many of the rules governing informal, administrative and judicial review proceedings were not required to be changed by 1998 Iowa Acts, chapter 1202. Accordingly, the following rules are incorporated by reference into this division and will govern their respective topics in relation to proceedings under this division:

701—7.4(17A) Computation of time, filing of documents;

701—7.5(17A) Form and style of papers;

701—7.7(17A) Resolution of tax liability;

701—7.18(17A) Interventions;

701—7.27(9C,91C) Procedure for nonlocal business entity bond forfeitures;

701—7.30(421) Definitions which apply to rule 701—7.31(421) to 701—7.35(421);

701—7.31(421) Abatement of unpaid tax;

701—7.32(421) Time and place of taxpayer interviews;

701—7.33(421) Mailing to the last-known address;

701—7.34(421) Power of attorney; and

701—7.35(421) Taxpayer designation of tax type and period to which voluntary payments are to be applied.

701—7.39(17A) Business hours. The principal office of the department in the Hoover State Office Building in Des Moines, Iowa, shall be open between the hours of 8 a.m. and 4:30 p.m. each weekday except Saturdays, Sundays and legal holidays as prescribed in Iowa Code section 4.1(34), for the purpose of receiving protests, pleadings, petitions, motions, requests for public information, copies of official documents, or for the opportunity to inspect public records.

All documents or papers required to be filed with the department by these rules shall be filed with the designated clerk of the hearings section in the principal office of the department in the Hoover State Office Building, Des Moines, Iowa 50319. Requests for public information or copies of official documents or the opportunity to inspect public records shall be made in the director's office at the department's principal office.

All documents or papers filed with an administrative law judge appointed by the division of administrative hearings to be a presiding officer shall be filed with the Department of Inspections and Appeals, Division of Administrative Hearings, Third Floor, Lucas State Office Building, Des Moines, Iowa 50319.

701—7.40(17A) Persons authorized to represent themselves or others. Due to the complex questions involved and the technical aspects of taxation, persons are encouraged to seek the aid, advice, assistance and counsel of practicing attorneys and certified public accountants.

The right to represent one's self or others in connection with any proceeding before the department or administrative hearings division shall be limited to the following classes of persons:

1. Taxpayers who are natural persons representing themselves;
2. Attorneys duly qualified and entitled to practice in the courts of the state of Iowa;
3. Attorneys who are entitled to practice before the highest court of record of any other state and who have complied with Iowa Ct. R. 31.14;
4. Accountants who are authorized, permitted, or licensed under Iowa Code chapter 542C;
5. Duly authorized directors or officers of corporations representing the corporation of which they are respectively a director or officer, excluding attorneys who are acting in the capacity of a director or officer of a corporation and who have not met the requirements of the third classification above;
6. Partners representing their partnership;
7. Fiduciaries;
8. Government officials authorized by law; or
9. Enrolled agents, currently enrolled under 31 CFR §10.6 for practice before the Internal Revenue Service, representing a taxpayer in proceedings under division II of Iowa Code chapter 422.

No person who has served as an official or employee of the department shall within a period of two years after the termination of such service or employment appear before the department or receive compensation for any services rendered on behalf of any person, firm, corporation, or association in relation to any case, proceeding, or application with respect to which the person was directly concerned and in which the person personally participated during the period of service or employment.

Any person appearing in any proceeding involving the department, regardless of whether the department is a party, must have on file with the department a valid Iowa power of attorney.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.41(17A) Protest. Any person wishing to contest an assessment, denial of refund claim, or any other department action, except licensing, which may culminate in a contested case proceeding shall file a protest, in writing, with the department within the time prescribed by the applicable statute or rule for filing notice of application to the director for a hearing. The protest must be either delivered

to the department by electronic means, United States Postal Service or a common carrier, by ordinary, certified, or registered mail, directed to the attention of the clerk of the hearings section for the department, personally delivered to the clerk of the hearings section for the department, or be served on the clerk of the hearings section for the department by personal service during business hours. For the purpose of mailing, a protest is considered filed on the date of the postmark. If a postmark date is not present on the mailed article, then the date of receipt of protest will be considered the date of mailing. Any document, including a protest, is considered filed the date personal service or personal delivery to the office of the clerk of the hearings section for the department is made. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

The period for appealing department action relating to refund claims is the same statutory period for contesting an assessment. Failure to timely file a written protest will be construed as a waiver of opposition to the matter involved unless, on the director's own motion, pursuant to statutory authority, the powers of abatement or settlement are exercised. The review unit, created within the department by the director to review protests as provided in 701—7.44(17A), may seek dismissal of protests which are not in the proper form as provided by this rule. See subrule 7.44(2) for dismissals.

If the department has not granted or denied a filed refund claim within six months of filing the claim, the refund claimant may file a protest. Even though a protest is so filed, the department is entitled to examine and inspect the refund claimant's records to verify the refund claim.

Notwithstanding the above, the taxpayer who fails to timely protest an assessment may contest the assessment by paying the whole assessed tax, interest, and penalty and by filing a refund claim within the time period provided by law for filing such claim. However, in the event that such assessment involves divisible taxes, which are not timely protested, namely, an assessment which is divisible into a tax on each transaction or event, the taxpayer can contest the assessment by paying a portion of the assessment and filing a refund claim within the time period provided by law. In this latter instance, the portion paid must represent any undisputed portion of the assessment and must also represent the liability on a transaction or event for which, if the taxpayer is successful in contesting the portion paid, the unpaid portion of the assessment would be canceled. *Flora v. United States,* 362 U.S. 145, 4 L.Ed. 2d 623, 80 S.Ct. 630 (1960); *Higginbotham v. United States,* 556 F.2d 1173 (4th Cir. 1977); *Steele v. United States,* 280 F.2d 89 (8th Cir. 1960); *Stern v. United States,* 563 F.Supp. 484 (D. Nev. 1983); *Drake v. United States,* 355 F. Supp. 710 (E.D. Mo. 1973). Any such protest filed is limited to the issues covered by the amounts paid for which a refund was requested and denied by the department. Thereafter, if the department does not grant or deny the refund within six months of the filing of the refund claim or if the department denies the refund, the taxpayer may file a protest as authorized by this rule.

All of the taxes administered and collected by the department can be divisible taxes, except individual income tax, fiduciary income tax, corporation income tax, franchise tax, and statewide property tax. The following noninclusive examples illustrate the application of the divisible tax concept.

EXAMPLE A. X is assessed withholding income taxes, penalty and interest, as a responsible party on eight employees. X fails to timely protest the assessment. X contends that X is not a responsible party. If X is a responsible party, X was required to make monthly deposits of the withholding taxes. In this situation, the withholding taxes are divisible. Therefore, X can pay an amount of tax, penalty and interest attributable to one employee for one month and file a refund claim within the time period provided by law since if X is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

EXAMPLE B. Y is assessed sales tax, interest, and penalty for electricity purchased and used to power a piece of machinery in Y's manufacturing plant. Y fails to timely protest the assessment. Y was billed monthly for electricity by the power company to whom Y had given an exemption certificate. Y contends that the particular piece of machinery is used directly in processing tangible personal property for sale and that, therefore, all of the electricity is exempt from sales tax. In this situation, the sales tax is divisible. Therefore, Y can pay an amount of tax, penalty and interest attributable to one month's electrical usage in that machinery and file a refund claim within the time period provided by law since if Y is successful on the refund claim the remaining unpaid portion of the assessment would be canceled.

The protest shall be brought by and in the name of the interested or affected person or by and in the full descriptive name of the fiduciary legally entitled to institute a proceeding on behalf of the person or by an intervenor in contested case proceedings. In the event of a variance in the name set forth in the protest and the correct name, a statement of the reason for the discrepancy shall be set forth in the protest. A protest which is filed shall contain:

7.41(1) A caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____ (state taxpayer's name and address and designate type of proceeding, e.g., income tax refund claim).	PROTEST DOCKET NO._____ (filled in by department)

7.41(2) Substantially state in separate numbered paragraphs the following:

a. Proper allegations showing:

(1) Date of assessment;

(2) Date of refund denial;

(3) Whether the protester failed to timely appeal the assessment and, if so, the date of payment and the date of filing the refund claim;

(4) Whether the protest involves the appeal of a refund claim after six months from the date of filing the refund claim because the department failed to deny the claim;

(5) Attach a copy of the assessment, refund claim, and refund denial;

(6) Other items that the protester wishes to bring to the attention of the department; and

(7) Request for attorney fees, if applicable.

b. The type of tax, the taxable period or periods involved and the amount in controversy;

c. Each error alleged to have been committed listed in a separate paragraph. For each error listed, provide an explanation of the error and all relevant facts related to the error;

d. Reference to any particular statute or statutes and any rule or rules involved, if known;

e. Description of records or documents which were not available or were not presented to department personnel prior to the filing of the protest, if any, and provide copies of any records or documents that were not previously presented to the department;

f. Any other matters deemed relevant and not covered in the above paragraphs;

g. The desire of protester to waive informal or contested case proceedings if it is desired; unless the protester so indicates a waiver, informal procedures will be initiated;

h. A statement setting forth the relief sought by the protester;

i. The signature of the protester or that of the protester's representative, the addresses of the protester and of the protester's representative, and the telephone number of the protester or the protester's representative; and

j. Attach a copy of power of attorney for protester's representative.

Upon receipt of the protest, the clerk of the hearings section for the department shall register the receipt of the protest, docket the protest, and shall assign a number to the case. The assigned number shall be placed on all subsequent pleadings filed in the case. An original and two copies of the protest shall be filed with the clerk of the hearings section of the department.

The protester may amend the protest at any time prior to the commencement of the evidentiary hearing. The department can request that protester amend the protest for purposes of clarification.

Upon the filing of an answer or if a demand for contested case is made by the protester, the clerk of the hearings section of the department will transfer the protest file to the division of administrative hearings established by 1998 Iowa Acts, chapter 1202, section 3, within 30 days of the date of the filing of the answer or the demand for contested case, unless the director determines not to transfer the case. If a party objects to a determination under 701—7.50(17A), the transfer, if any, would be made after the director makes a ruling on the objection.

7.41(3) Denial of renewal of vehicle registration or denial of issuance or renewal, or suspension, of a driver's license. A person who has had an application for renewal of vehicle registration denied or has been denied the issuance of a driver's license or the renewal of a driver's license, or has had a driver's license suspended may file a protest with the clerk of the hearings section for the department if the denial of the issuance or renewal or the suspension is because the person owes delinquent taxes.

The issues raised in a protest by the person, which are limited to a mistake of fact, may include but are not limited to:

1. The person has the same name as the obligor but is not the correct person;
2. The amount in question has been paid; or
3. The person has made arrangements with the department to pay the amount.

701—7.42(17A) Identifying details. Any person may file a motion to delete identifying details concerning the person from any document relating to any proceedings as defined in rule 701—7.37(17A) prior to disclosure to members of the public. Such a motion must be filed with the clerk of the hearings section for the department if the motion is filed prior to the commencement of a contested case, which is before the Notice for Hearing is issued. If the motion is filed during a contested case proceeding pending before an administrative law judge and before the administrative law judge has entered a proposed decision on the case or has entered a closing order, the motion must be filed with and ruled upon by the administrative law judge. Otherwise, the motion must be filed with the clerk of the hearings section and ruled upon by the director. The motion shall be filed simultaneously with the presentation of the privacy or trade secret information under circumstances whereby the information may be disclosed to the public and before the issuance of any opinion, order or decision.

If the motion concerns information which is not a part of a contested case, the motion shall be in the form of a request to delete identifying details; if part of a contested case, the motion shall be in the form of a motion to delete identifying details. All motions to delete shall conform to subrule 7.50(4). The motion or request shall contain the following:

1. The name of the person requesting deletion and the docket number of the proceeding, if applicable;
2. The legal basis for the request for deletion, which is either that the material would be a clearly unwarranted invasion of personal privacy or the material is a trade secret. A corporation may not claim an unwarranted invasion of privacy;
3. A precise description of the document, report, or other material in the possession of the department from which the deletion is sought, and a precise description of the information to be deleted. If deletion is sought from more than one document, each document and the materials sought to be deleted from it shall be listed in separate paragraphs. Also contained in each separate paragraph shall be a statement of the legal basis for the deletion requested in that paragraph, which is that the material sought to be deleted is a clearly unwarranted invasion of privacy or is a trade secret and the material serves no public purpose;
4. An affidavit in support of deletion must accompany each motion or request. The affidavit must be sworn to by a person familiar with the facts asserted within it and shall contain a clear and concise explanation of the facts justifying deletion, not merely the legal basis for deletion or conclusionary allegations;
5. All affidavits shall contain a general and truthful statement that the information sought to be deleted is not available to the public from any source or combination of sources, direct or indirect, and a general statement that the release would serve no public purpose;
6. The burden of showing that deletion is justified shall be on the movant. The burden is not carried by mere conclusionary statements or allegations, for example, that the release of the material would be a clearly unwarranted invasion of personal privacy or that the material is a trade secret;
7. In the event that the matter sought to be deleted is part of the pleadings, motions, evidence, and the record in a contested case proceeding otherwise open for public inspection, and that the matter would otherwise constitute confidential tax information shall not be grounds for deletion (1992 Op. Att'y Gen. 1.); and

8. The ruling on the motion shall be strictly limited to the facts and legal bases presented by the movant, and the ruling shall not be based upon any facts or legal bases not presented by the movant.

701—7.43(17A) Docket. The clerk of the hearings section for the department shall maintain a docket of all proceedings, and each of the proceedings shall be assigned a number. Every matter coming within the purview of these rules shall be assigned a docket number which shall be the official number for the purposes of identification. Upon receipt of a protest, petition for declaratory order or petition to initiate rule-making proceedings, the proceeding will be docketed and assigned a number, and the parties notified thereof. The number shall be placed by the parties on all papers thereafter filed in the proceeding. After the transfer of a case to the division of administrative hearings for contested case proceedings, that division may assign a docket number to the case and in that event, the docket number shall be placed by the parties on all papers thereafter filed in the proceeding.

701—7.44(17A) Informal procedures and dismissals of protests.

7.44(1) *Informal procedures.* Persons are encouraged to utilize the informal procedures provided herein so that a settlement may be reached between the parties without the necessity of initiating contested case proceedings. Therefore, unless the protester indicates a desire to waive the informal procedures in the protest or the department waives informal procedures upon notification to the protester, such informal procedures will be initiated as herein provided upon the filing of a proper protest.

a. Review unit. A review unit is created within the department and, subject to the control of the director, the unit will:

(1) Review and evaluate the validity of all protests made by taxpayers from the department action.

(2) Determine the correct amount of tax owing or refund due.

(3) Determine the best method of resolving the dispute between the protester and the department.

(4) Take further action regarding the protest, including any additions and deletions to the audit, as may be warranted by the circumstances to resolve the protest, including a request for an informal conference.

(5) Determine whether the protest complies with rule 701—7.41(17A) and request any amendments to the protest or additional information.

The review unit may concede any items contained in the protest which it determines should not be controverted by the department. If the protester has not waived informal procedures, the review unit may request the protester and the protester's representative, if any, to attend an informal conference with the review unit to explore the possibility of reaching a settlement without the necessity of initiating contested case proceedings or of narrowing the issues presented in the protest if no settlement can be made. The review unit may request clarification of the issues from the protester or further information from the protester or third persons.

Findings dealing with the issues raised in the protest may be issued unless the issues may be more expeditiously determined in another manner or it is determined that findings are unnecessary. The protester will be notified of the decision on the issues in controversy.

Nothing herein will prevent the review unit and the protester from mutually agreeing on the manner in which the protest will be informally reviewed.

b. Settlements. If a settlement is reached during informal procedures, the clerk of the hearings section must be notified. A closing order shall be issued by the director and served upon all parties, stating that a settlement was reached by the parties and that the case is terminated.

7.44(2) *Dismissal of protests.*

a. Whether informal procedures have been waived or not, the failure of the protester to timely file a protest or to pursue the protest may be grounds for dismissal of the protest by the director or the director's designee. If the protest is so dismissed, the protester may file an application for reinstatement of the protest for good cause as provided in paragraph *"c"* of this subrule. Such application must be filed within 30 days of the date of the dismissal notice. Thereafter, the procedure in paragraph *"c"* of the subrule should be followed. If informal procedures have not been waived, the failure of the protester to present evidence or information requested by the review unit shall constitute grounds for the director

or the director's designee to dismiss the protest. For purposes of this subrule, an evasive or incomplete response will be treated as a failure to present evidence or information. The failure of protester to file a protest in the format required by rule 701—7.41(17A) may be grounds for dismissal of the protest by the director or the director's designee.

b. If the department seeks to have the protest dismissed, the review unit shall file a motion to dismiss with the clerk of the hearings section for the department and serve a copy of the motion on the protester. Protester may file a resistance to the motion within 20 days of the date of service of the motion. If no resistance is so filed, the director or the director's designee shall immediately enter an order dismissing the protest. If a resistance is filed, the review unit has ten days from the date of the filing of the resistance to decide whether to withdraw its motion and so notify the clerk of the hearings section for the department and protester. If no such notice is issued by the review unit within the ten-day period, the protest file will be transferred to the division of administrative hearings, which shall issue a notice for a contested case proceeding on the motion as prescribed by rule 701—7.47(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be dismissed. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such dismissal proceedings.

c. If a motion to dismiss is filed and is unresisted, a protest so dismissed may be reinstated by the director or the director's designee for good cause as interpreted by the Iowa Supreme Court in the case of *Purethane, Inc. v. Iowa State Board of Tax Review,* 498 N.W.2d 706 (Iowa 1993) if an application for reinstatement is filed with the clerk of the hearings section for the department within 30 days of the date the protest was dismissed. The application shall set forth all reasons and facts upon which the protester relies in seeking reinstatement of the protest. The review unit shall review the application and notify the protester whether the application is granted or denied. If the review unit denies the application to reinstate the protest, the protester has 30 days from the date the application for reinstatement was denied in which to request, in writing, a formal hearing on the reinstatement. When a written request is received, the protest file will be transferred to the division of administrative hearings which shall issue a notice as prescribed in rule 701—7.47(17A), except that the issue of the contested case proceeding shall be limited to the question of whether the protest shall be reinstated. Thereafter, the rules of the department pertaining to contested case proceedings shall apply in such reinstatement proceedings.

d. Once contested case proceedings have been commenced, whether informal proceedings have been waived or not, it shall be grounds for a motion to dismiss that a protester has either failed to diligently pursue the protest or refuses to comply with requests for discovery set forth in rule 701—7.47(17A). Such a motion must be filed with the presiding officer.

e. Notwithstanding other provisions of this subrule, if the director finds that a protest is not timely filed, including a failure within a reasonable time to file a protest in proper form after notice to protester by the hearings section, the director, without the filing of a motion to dismiss, may dismiss the protest and shall notify the protester that the protest has been dismissed. With respect to a protest so dismissed, thereafter the provisions of paragraph *"c"* of this subrule shall apply.

701—7.45(17A) Answer. The department may, in lieu of findings, file an answer. When findings are issued, the department will file an answer within 30 days of receipt of written notification from protester stating disagreement with the findings. The answer shall be filed with the clerk of the hearings section for the department.

In the event that the protester does not so respond in writing to the findings issued on matters covered by subrule 7.44(1) within 30 days after being notified, the department may seek dismissal of the protest pursuant to subrule 7.44(2).

The answer of the department shall be drawn in a manner as provided by the Iowa Rules of Civil Procedure for answers filed in Iowa district courts.

Each paragraph contained in the answer shall be numbered or lettered to correspond, where possible, with the paragraphs of the protest. An original copy only of the answer shall be filed with the clerk of the hearings section for the department and shall be signed by the department's counsel or representative.

The department shall forthwith serve a copy of the answer upon the representative of record or, if there is no representative of record, then upon the protester and shall file proof of service with the clerk of the hearings section of the department at the time of filing of the answer. The department may amend its answer at any time prior to the commencement of the evidentiary hearing.

The provisions of rule 701—7.45(17A) shall be considered as a part of the informal procedures since a contested case proceeding, at the time of filing the answer, has not yet commenced. However, an answer shall be filed pursuant to this rule whether or not informal procedures have been waived by the protester or the department.

Notwithstanding the above portions of this rule, if a taxpayer makes a written demand for a contested case proceeding, as authorized by rule 701—7.47(17A), after a period of six months from the filing of a proper protest, the department shall file its answer within 30 days after receipt of the demand. If the department fails to file its answer within this 30-day period, interest shall be suspended, if the protest involves an assessment, from the time that the department was required to answer until the date that the department files its answer and, if the protest involves a refund, interest shall accrue on the refund at double the rate from the time the department was required to answer until the date that the department files its answer.

The department's answer may contain a statement setting forth whether the case should be transferred to the division of administrative hearings or the director should retain the case for hearing.

The department's answer should set forth the basis for retention of the case by the director as provided in subrule 7.50(1). If the answer fails to allege that the case should be retained by the director, the case should be transferred to the division of administrative hearings for contested case proceedings, unless the director determines on the director's own motion that the case should be retained by the director.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code sections 421.14 and 421.60.

701—7.46(17A) Subpoenas. Prior to the commencement of a contested case, the department shall have the authority to subpoena books, papers, and records and shall have all other subpoena powers conferred upon it by law. Subpoenas in this case shall be issued by the director or the director's designee. Once a contested case is commenced, subpoenas must be issued by the presiding officer.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code section 421.14.

701—7.47(17A) Commencement of contested case proceedings. A demand or request by the protester for the commencement of contested case proceedings must be in writing and filed with the clerk of the hearings section by electronic means, by mail via the United States Postal Service or common carrier by ordinary, certified, or registered mail in care of the clerk of the hearings section of the department, or by personal service on the office of the clerk of the hearings section for the department during business hours. The demand or request is considered filed on the date of the postmark. If the demand or request does not indicate a postmark date, then the date of receipt or the date personal service is made is considered the date of filing. See Iowa Code section 622.105 for the evidence necessary to establish proof of mailing.

At the request of a party or the presiding officer made prior to the issuance of the hearing notice, the presiding officer shall hold a telephone conference with the parties for the purpose of selecting a mutually agreeable hearing date, which date shall be the hearing date contained in the hearing notice. The notice shall be issued within one week after the mutually agreeable hearing date is selected.

Contested case proceedings will be commenced by the presiding officer by delivery of notice by ordinary mail directed to the parties after a demand or request is made (1) by the protester and the filing of the answer, if one is required, which demand or request may include a date to be set for the hearing, or (2) upon filing of the answer, if a request or demand for contested case proceedings has not been made by the protester. The notice will be given by the presiding officer.

The presiding officer may grant a continuance of the hearing. Any change in the date of the hearing shall be set by the presiding officer. Either party may apply to the presiding officer for a specific date for the hearing. The notice shall include:

1. A statement of the time (which shall allow for a reasonable time to conduct discovery), place and nature of the hearing;
2. A statement of the legal authority and jurisdiction under which the hearing is held;
3. A reference to the particular sections of the statutes and rules involved; and
4. A short and plain statement of the matters asserted, including the issues.

After the delivery of the notice commencing the contested case proceedings, the parties may file further pleadings or amendments to pleadings as they desire. However, any pleading or amendment thereto which is filed within seven days prior to the date scheduled for the hearing or filed on the date of the hearing shall constitute good cause for the party adversely affected by the pleading or amendment to seek and obtain a continuance.

This rule is intended to implement Iowa Code sections 17A.12 and 421.8A.

701—7.48(17A) Discovery. The rules of the Supreme Court of the state of Iowa applicable in civil proceedings with respect to depositions upon oral examination or written questions; written interrogatories; production of documents or things or permission to enter upon land or other property, for inspection and other purposes; physical and mental examinations; and requests for admission shall apply to discovery procedures in contested case proceedings. Disputes concerning discovery shall be resolved by the presiding officer. If necessary a hearing shall be scheduled, with reasonable notice to the parties and upon hearing an appropriate order shall be issued by the presiding officer.

When the department relies on a witness in a contested case, whether or not a departmental employee, who has made prior statements or reports with respect to the subject matter of the witness' testimony, it shall, on request, make such statements or reports available to a party for use on cross-examination, unless those statements or reports are otherwise expressly exempt from disclosure by constitution or statute. Identifiable departmental records that are relevant to disputed material facts involved in a contested case shall, upon request, promptly be made available to the party unless the requested records are expressly exempt from disclosure by constitution or statute.

Evidence obtained in such discovery may be used in contested case proceedings if that evidence would otherwise be admissible in the contested case proceeding.

This rule is intended to implement Iowa Code chapter 17A and Iowa Code section 421.14.

701—7.49(17A) Prehearing conference. Upon the motion of the presiding officer, or upon the written request of a party, the presiding officer shall direct the parties to appear at a specified time and place before the presiding officer for a prehearing conference to consider:

1. The possibility or desirability of waiving any provisions of the Act relating to contested case proceedings by written stipulation representing an informed mutual consent;
2. The necessity or desirability of setting a new date for hearing;
3. The simplification of issues;
4. The necessity or desirability of amending the pleadings either for the purpose of clarification, amplification or limitation;
5. The possibility of agreeing to the admission of facts, documents or records not really controverted, to avoid unnecessary introduction of proof;
6. The procedure at the hearing;
7. Limiting the number of witnesses;
8. The names and identification of witnesses and the facts each party will attempt to prove at the hearing;
9. Conduct or schedule of discovery; and
10. Such other matters as may aid, expedite or simplify in the disposition of the proceeding.

Any action taken at the prehearing conference shall be recorded in an appropriate order, unless the parties enter upon a written stipulation as to such matters or agree to a statement thereof made on the record by the presiding officer.

When an order is issued at the termination of the prehearing conference, a reasonable time shall be allowed to the parties to present objections on the grounds that it does not fully or correctly embody

the agreements at such conference. Thereafter, the terms of the order or modification thereof shall determine the subsequent course of the proceedings relative to matters it includes, unless modified to prevent manifest injustice.

If either party to the contested case proceeding fails to appear at the prehearing conference, fails to request a continuance, or fails to submit evidence or arguments which the party wishes to be considered in lieu of appearance, the opposing party may move for dismissal. The motion shall be made in accordance with subrule 7.50(4).

This rule is intended to implement Iowa Code section 17A.12.

701—7.50(17A) Contested case proceedings. Unless the parties to a contested case proceeding have, by written stipulation representing an informed mutual consent, waived the provisions of the Act relating to such proceedings, contested case proceedings shall be initiated and culminate in an evidentiary hearing open to the public.

Evidentiary hearings in which the presiding officer is an administrative law judge employed by the division of administrative hearings, shall be held at the location designated in the notice of evidentiary hearing. Generally, the location for evidentiary hearings in such cases will be at the principal office of the Department of Inspections and Appeals, Lucas State Office Building, Des Moines, Iowa 50319.

If the director retains a contested case, generally, the location for the evidentiary hearing will be at the main office of the department at the Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50309. However, the department retains the discretion to change the location of the evidentiary hearing if necessary. The location of the evidentiary hearing will be designated in the notice of hearing issued by the director.

7.50(1) *Determination of presiding officer.* If the director retains a contested case for evidentiary hearing and the department is a party, the initial presiding officer will be the director. If the department is not a party to the contested case retained by the director, the presiding officer may be the director or the director's designee. Upon determining that a case will be retained and not transferred to the division of administrative hearings, the director shall issue written notification to the parties of the determination which states the basis for retaining the case for evidentiary hearing.

The director may determine to retain a contested case for evidentiary hearing and decision upon the filing by the department of its answer under rule 701—7.45(17A). If the answer failed to allege that the case should be retained by the director and the case was transferred to the division of administrative hearings for contested case proceedings, either party may, within a reasonable time after the issuance of the hearing notice provided in rule 701—7.47(17A), make application to the director to recall and retain the case for hearing and decision. Any such application shall be served upon the assigned administrative law judge or presiding officer.

A protester may file a written objection to the director's determination to retain the case for evidentiary hearing and request that the contested case be heard by an administrative law judge or presiding officer and request a hearing on the objection. Such an objection must be filed with the clerk of the hearings section for the department within 20 days of the notice issued by the director of the director's determination to retain the case. The director may retain the case only upon a finding that one or more of the following apply:

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

b. A qualified administrative law judge is unavailable to hear the case within a reasonable time;

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

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

e. The case involves an issue or issues the resolution of which would create important precedent;

f. The case involves complex or extraordinary questions of law or fact;

g. The case involves issues or questions of law or fact that, based on the director's discretion, should be retained by the director;

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

i. The request was not timely filed;

j. The request is not consistent with a specified statute; and

k. An assignment of the administrative law judge will result in lengthening the time for issuance of a proposed decision, after the case is submitted, beyond a reasonable time as provided in subrule 7.50(7). In making this determination, the director shall consider whether the assigned administrative law judge has a current backlog of submitted cases for which decisions have not been issued for one year after submission.

The director shall issue a written ruling specifying the grounds for the decision within 20 days after a request for an administrative law judge is filed. If a party objects to the director's determination to retain a case for evidentiary hearing, transfer of the protest file, if any, will be made after the director makes a final determination on the objection. If the ruling is contingent upon the availability of a qualified administrative law judge, the parties shall be notified at least ten days prior to the hearing if a qualified administrative law judge will be available.

If there is no factual conflict or credibility of evidence offered in issue, either party, after the contested case has been heard and a proposed decision is pending with a presiding officer other than the director for at least one year, may make application to the director to transfer the case to the director for decision. In addition, if the aforementioned criteria exist, the director, on the director's own motion, may issue a notice to the parties of the director's intention to transfer the case to the director for decision. The opposing party may file, within 20 days after service of such application or notice by the director, a resistance setting forth in detail why the case should not be transferred. If the director approves the transfer of the case, the director shall issue a final contested case decision. The director or a party may request that the parties be allowed to submit proposed findings of fact and conclusions of law.

The director has the right to require that any presiding officer, other than the director, be a licensed attorney in the state of Iowa, unless the contested case only involves licensing. In addition, any presiding officer must possess, upon determination by the director, sufficient technical expertise and experience in the areas of taxation and presiding over proceedings to effectively determine the issues involved in the proceeding.

Except as provided otherwise by another provision of law, all rulings by an administrative law judge acting as presiding officer are subject to appeal to the director.

7.50(2) *Conduct of proceedings.* A proceeding shall be conducted by a presiding officer who, among other things, shall:

a. Open the record and receive appearances;

b. Administer oaths and issue subpoenas;

c. Enter the notice of hearing into the record;

d. Receive testimony and exhibits presented by the parties;

e. In the presiding officer's discretion, interrogate witnesses;

f. Rule on objections and motions;

g. Close the hearing; and

h. Issue an order containing findings of fact and conclusions of law.

The presiding officer may resolve preliminary procedural motions by telephone conference in which all parties have an opportunity to participate. Other telephone proceedings may be held with the consent of all parties. The presiding officer will determine the location of the parties and witnesses for telephone hearing. The convenience of the witnesses or parties, as well as the nature of the case, will be considered when location is chosen. Parties shall be notified at least 30 days in advance of the date and place of the hearing.

Evidentiary proceedings shall be oral and open to the public and shall be recorded either by mechanical means or by certified shorthand reporters. Parties requesting that the hearing be recorded by certified shorthand reporters shall bear the appropriate costs. The record of the oral proceedings or the transcription thereof, shall be filed with and maintained by the department for at least five years from the date of the decision. An opportunity shall be afforded to the parties to respond and present evidence and argument on all issues involved and to be represented by counsel at their own expense. Unless otherwise directed by the presiding officer, evidence will be received in the following order: (1)

protester, (2) intervenor (if applicable), (3) department, (4) rebuttal by protester, (5) oral argument by parties (if necessary).

If the protester or the department appears without counsel or other representative who can reasonably be expected to be familiar with these rules, the presiding officer shall explain to the parties the rules of practice and procedure and generally conduct a hearing in a less formal manner than that used when the parties have such representatives appearing upon their behalf. It should be the purpose of the presiding officer to assist any party appearing without such representative to the extent necessary to allow the party to fairly present evidence, testimony, and arguments on the issues. The presiding officer shall take whatever steps may be necessary and proper to ensure that all evidence having probative value is presented and that each party is accorded a fair hearing.

If the parties have mutually agreed to waive the provisions of the Act in regard to contested case proceedings, the hearing will be conducted in a less formal manner than when an evidentiary hearing is conducted.

If a party fails to appear in a contested case proceeding after proper service of notice, the presiding officer may, upon the presiding officer's own motion or upon the motion of the party who has appeared, adjourn the hearing, enter a default decision, or proceed with the hearing and make a decision on the merits in the absence of the party.

Contemptuous conduct by any person appearing at a hearing shall be grounds for the person's exclusion from the hearing by the presiding officer.

A stipulation by the parties of the issues or a statement of the issues in the notice commencing the contested case cannot be changed by the presiding officer without the consent of the parties. The presiding officer shall not, on the presiding officer's own motion, change or modify the issues agreed upon by the parties. Notwithstanding the provisions of this paragraph, a party within a reasonable time prior to the hearing may request that a new issue be addressed in the proceedings, except that the request cannot be made after the parties have stipulated to the issues.

7.50(3) *Rules of evidence.* In evaluating evidence, the department's experience, technical competence, and specialized knowledge may be utilized.

a. Oath. All testimony presented before the presiding officer shall be given under oath which the presiding officer has authority to administer.

b. Production of evidence and testimony. The presiding officer may issue subpoenas to a party on request, as permitted by law, compelling the attendance of witnesses and the production of books, papers, records, or other real evidence.

c. Subpoena. When a subpoena is desired after the commencement of a contested case proceeding, the proper party shall indicate to the presiding officer the name of the case, the docket number and the last-known addresses of the witnesses to be called. If evidence other than oral testimony is required, each item to be produced must be adequately described. When properly prepared by the presiding officer, the subpoena will be returned to the requesting party for service. Service may be made in any manner allowed by law before the hearing date of the case which the witness is required to attend. No costs for serving a subpoena will be allowed if it is served by any person other than the sheriff. Subpoenas requested for discovery purposes shall be issued by the presiding officer.

d. Admissibility of evidence.

(1) Evidence having probative value. Although the presiding officer is not bound to follow the technical common law rules of evidence, a finding shall be based upon the kind of evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs, and may be based upon such evidence even if it would be inadmissible in a jury trial. Therefore, the presiding officer may admit and give probative effect to evidence on which reasonably prudent persons are accustomed to rely for the conduct of their serious affairs. Irrelevant, immaterial, or unduly repetitious evidence shall be excluded. The presiding officer shall give effect to the rules of privilege recognized by law. Evidence not provided to a requesting party through discovery shall not be admissible at the hearing. Subject to these requirements, when a hearing will be expedited and the interests of the parties will not be prejudiced, substantially any part of the evidence may be required to be submitted in verified written form by the presiding officer.

Objections to evidentiary offers may be made at the hearing and the presiding officer's ruling thereon shall be noted in the record.

(2) Evidence of a federal determination. Evidence of a federal determination whether it be a treasury department ruling, regulation or determination letter, a federal court decision or an Internal Revenue Service assessment relating to issues raised in the proceeding shall be admissible, and the protester shall be presumed to have conceded the accuracy of it unless the protester specifically states wherein it is erroneous.

(3) Copies of evidence. A copy of any book, record, paper or document may be offered directly in evidence in lieu of the original, if the original is not readily available or if there is no objection. Upon request, the parties shall be given an opportunity to compare the copy with the original, if available.

(4) Stipulations. Approval of the presiding officer is not required for stipulations of the parties to be used in contested case proceedings. In the event the parties file a stipulation in the proceedings, the stipulation shall be binding on the parties and the presiding officer.

e. Exhibits.

(1) Identification of exhibits. Exhibits attached to a stipulation or entered in evidence which are offered by protesters shall be numbered serially, i.e., 1, 2, 3, etc.; whereas, those offered by the department shall be lettered serially, i.e., A, B, C, etc.; and those offered jointly shall be numbered and lettered, i.e., 1-A, 2-B, 3-C, etc.

(2) Disposition of exhibits. After an order has become final, either party desiring the return, at the party's expense, of any exhibit belonging to the party, shall make application in writing to the clerk of the hearings section for the department within 30 days suggesting a practical manner of delivery; otherwise, exhibits may be disposed of as the clerk of the hearings section for the department deems advisable.

f. Official notice. The presiding officer may take official notice of all facts of which judicial notice may be taken. Parties shall be notified at the earliest practicable time, either before or during the hearing, or by reference in preliminary reports, preliminary decisions or otherwise, of the facts proposed to be noticed and their source, including any staff memoranda or data. The parties shall be afforded an opportunity to contest such facts prior to the issuance of the decision in the contested case proceeding unless the presiding officer determines as a part of the record or decision that fairness to the parties does not require an opportunity to contest such facts.

g. Evidence outside the record. Except as provided by these rules, the presiding officer shall not consider factual information or evidence in the determination of any proceeding unless the same shall have been offered and made a part of the record in the proceeding.

h. Presentation of evidence and testimony. In any hearing each party thereto shall have the right to present evidence and testimony of witnesses and to cross-examine any witness who testifies on behalf of an adverse party. Persons whose testimony has been submitted in written form, if available, shall also be subject to cross-examination by an adverse party. Opportunity shall be afforded each party for re-direct examination and re-cross examination and to present evidence and testimony as rebuttal to evidence presented by another party, except that unduly repetitious evidence shall be excluded.

i. Offer of proof. An offer of proof may be made through the witness or by statement of counsel. The party objecting may cross-examine the witness without waiving any objection.

7.50(4) *Motions.* After commencement of contested case proceedings, appropriate motions may be filed by any party with the presiding officer when facts requiring such motion come to the knowledge of the party. All motions shall state the relief sought and the grounds upon which the same are based.

Motions made prior to a hearing shall be in writing and a copy thereof served on all parties and attorneys of record. Such motions shall be ruled on by the presiding officer. The presiding officer shall rule on the motion by issuing an order. A copy of the order containing the ruling on the motion shall be mailed to the parties and authorized representatives. Motions may be made orally during the course of a hearing; however, the presiding officer may request that it be reduced to writing and filed with the presiding officer.

To avoid a hearing on a motion, it is advisable to secure the consent of the opposing party prior to filing the motion. If consent of the opposing party to the motion is not obtained, a hearing on the motion

may be scheduled and the parties notified. The burden will be on the party filing the motion to show good cause why the motion should be granted.

The party making the motion may affix thereto such affidavits as are deemed essential to the disposition of the motion, which shall be served with the motion and to which the opposing party may reply with counter affidavits.

a. Types of motions. Types of motions include, but are not limited to:

(1) Motion for continuance. Motions for continuance should be filed no later than ten days before the scheduled date of the contested case hearing unless the grounds for the motion are first known to the moving party within ten days of the hearing, in which case the motion shall be promptly filed and shall set forth why it could not be filed at least ten days prior to the hearing. Grounds for motion for continuance include, but are not limited to, the following:

1. Unavailability of a party, a party's representative or a witness;
2. Incompletion of discovery; and
3. Possibility of settlement of the case.

(2) Motion for dismissal;

(3) Motion for summary judgment;

(4) Motion to delete identifying details in the decision;

(5) Motion for default; and

(6) Motion to vacate default.

b. Hearing on motions. Motions subsequent to the commencement of a contested case proceeding shall be determined by the presiding officer.

c. Summary judgment procedure. Summary judgment may be obtained under the following conditions and circumstances:

(1) A party may, after a reasonable time to complete discovery, after completion of discovery, or by agreement of the parties, move with or without supporting affidavits for a summary judgment in the party's favor upon all or any part of a party's claim or defense.

(2) The motion shall be filed not less than 45 days prior to the date the case is set for hearing, unless otherwise ordered by the presiding officer. Any party resisting the motion shall file within 30 days from the time of service of the motion a resistance; statement of disputed facts, if any; and memorandum of authorities supporting the resistance. If affidavits supporting the resistance are filed, they must be filed with the resistance. The time fixed for hearing or normal submission on the motion shall be not less than 35 days after the filing of the motion, unless another time is ordered by the presiding officer. The judgment sought shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

(3) Upon any motion for summary judgment pursuant to this rule, there shall be affixed to the motion a separate, short, and concise statement of the material facts as to which the moving party contends there is no genuine issue to be tried, including specific reference to those parts of the pleadings, depositions, answers to interrogatories, admissions on file, and affidavits which support such contentions and a memorandum of authorities.

(4) Supporting and opposing affidavits shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein. The presiding officer may permit affidavits to be supplemented or opposed by depositions, answers to interrogatories, further affidavits, or oral testimony. When a motion for summary judgment is made and supported as provided in this rule, an adverse party may not rest upon the mere allegations or denials of the party's pleading, but the party's response must set forth specific facts, by affidavits or as otherwise provided in this rule, showing that there is a genuine issue for hearing. If the party does not so respond, summary judgment, if appropriate, shall be entered against the party.

(5) If on motion under this rule judgment is not rendered upon the whole case or for all the relief asked and a hearing is necessary, the presiding officer at the hearing of the motion, by examining the pleadings and the evidence before the presiding officer and by interrogating counsel, shall, if practicable, ascertain what material facts exist without substantial controversy and what material facts are actually,

and in good faith, controverted. The presiding officer shall thereupon make an order specifying the facts that appear without substantial controversy, including the extent to which the amount or other relief is not in controversy, and directing such further proceedings in the action as are just. Upon the hearing of the contested case, the facts so specified shall be deemed established, and the hearing shall be conducted accordingly.

(6) Should it appear from the affidavits of a party opposing the motion that the party cannot for reasons stated present, by affidavit, facts essential to justify the party's opposition, the presiding officer may refuse the application for judgment, may order a continuance to permit affidavits to be obtained, may order depositions be taken or discovery be completed, or may make any other order appropriate.

(7) An order on summary judgment that disposes of less than the entire case is appealable to the director at the same time that the proposed order is appealable pursuant to subrule 7.50(7).

7.50(5) *Briefs and oral argument.* At any time, upon the request of any party or in the presiding officer's discretion, the presiding officer may require the filing of briefs on any of the issues before the presiding officer prior to or at the time of hearing, or at a subsequent time. At the hearing, the parties should be prepared to make oral arguments as to the facts and law at the conclusion of the hearing if the presiding officer so directs.

An original copy only of all briefs shall be filed. Filed briefs shall conform to the requirements of 701—7.5(17A).

If the parties agree on a schedule for submission of briefs, the schedule shall be binding on the parties and the presiding officer except that, for good cause shown, the time may be extended upon application of a party.

7.50(6) *Defaults.* If a party fails to appear or participate in a contested case proceeding after proper service of notice, the presiding officer may, if no adjournment is granted, enter a default decision or proceed with the hearing and render a decision in the absence of the party.

a. Where appropriate and not contrary to law, any party may move for default against a party who has failed to file a required pleading or has failed to appear after proper service.

b. A default decision or a decision rendered on the merits after a party failed to appear or participate in a contested case proceeding becomes a final department action unless, within 15 days after the date of notification or mailing of the decision, a motion to vacate is filed and served on all parties or an appeal of a decision on the merits is timely initiated within the time provided in subrule 7.50(7). A motion to vacate must state all facts relied upon by the moving party which establish that good cause existed for that party's failure to appear or participate at the contested case proceeding. Each fact so stated must be substantiated by at least one sworn affidavit of a person with personal knowledge of each such fact, and such affidavit(s) must be attached to the motion.

c. The time for further appeal of a decision for which a timely motion to vacate has been filed is stayed pending a decision on the motion to vacate.

d. Properly substantiated and timely filed motions to vacate shall be granted only for good cause shown. The burden of proof as to good cause is on the moving party. Adverse parties shall have ten days to respond to a motion to vacate. Adverse parties shall be allowed to conduct discovery as to the issue of good cause and to present evidence on the issue prior to a decision on the motion, if a request to do so is included in that party's response.

e. "Good cause" for purposes of this rule shall have the same meaning as "good cause" as interpreted in the case of *Purethane, Inc. v. Iowa State Board of Tax Review,* 498 N.W.2d 706 (Iowa 1993).

f. A decision denying a motion to vacate is subject to further appeal within the time limit allowed for further appeal of a decision on the merits in the contested case proceeding. A decision granting a motion to vacate is subject to interlocutory appeal by the adverse party as provided in subrule 7.50(12).

g. If a motion to vacate is granted and no timely interlocutory appeal has been taken, the presiding officer shall issue another notice of hearing and the contested case shall proceed accordingly.

h. A default decision may award any relief consistent with the request for relief by the party in whose favor the default decision is made and embraced in the contested case issues; but unless the defaulting party has appeared, it cannot exceed the relief demanded.

i. A default decision may provide either that the default decision is to be stayed pending a timely motion to vacate or that the default decision is to take effect immediately, subject to a request for a stay.

7.50(7) *Orders.* At the conclusion of the hearing, the presiding officer in the presiding officer's discretion, may request the parties to submit proposed findings of fact and conclusions of law. Upon the request of any party, the presiding officer shall allow the parties an opportunity to submit proposed findings of fact and conclusions of law. In addition to or in lieu of the filing of briefs, upon the request of all of the parties waiving any contrary contested case provisions of law or of these rules, the presiding officer shall allow the parties to submit proposed findings of fact and conclusions of law and the presiding officer may sign and adopt as the decision or proposed decision one of such proposed findings of fact and conclusions of law without any changes.

The decision in a contested case is an order which shall be in writing or stated in the record. The order shall include findings of fact prepared by the person presiding at the hearing, unless the person is unavailable, and based solely on the evidence in the record and on matters officially noticed in the record, and shall include conclusions of law. The findings of fact and conclusions of law shall be separately stated. If a party has submitted proposed findings of fact, the order shall include a ruling upon each proposed finding. Each conclusion of law shall be supported by cited authority or by a reasoned opinion. The decision must include an explanation of why the relevant evidence in the record supports each material finding of fact. If the issue of reasonable litigation costs was held in abeyance pending the outcome of the substantive issues in the contested case and the proposed order decides substantive issues in favor of protester, the proposed order shall include a notice of time and place for a hearing on the issue of whether reasonable litigation costs shall be awarded and on the issue of the amount of such award, unless the parties agree otherwise. All decisions and orders in a contested case proceeding shall be based solely on the legal bases and arguments presented by the parties. In the event that the presiding officer believes that a legal basis or argument for a decision or order exists, but has not been presented by the parties, the presiding officer shall notify the parties and give them an opportunity to file a brief that addresses such legal basis or argument.

When a motion has been made to delete identifying details in an order on the basis of personal privacy or trade secrets, the justification for such deletion or refusal to delete shall be made by the moving party and shall appear in the order.

When the director initially presides at a hearing or considers decisions on appeal from or review of a proposed decision by the presiding officer other than the director, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to or review on motion of a second agency within the time provided by statute or rule. When a presiding officer other than the director presides at the hearing, the order becomes the final order of the department for purposes of judicial review or rehearing unless there is an appeal to or review on motion of the director within 30 days of the date of the order, or 10 days, excluding Saturdays, Sundays, and legal holidays, for a revocation order pursuant to rule 701—7.55(17A). However, if the contested case proceeding involves a question of an award of reasonable litigation costs, the proposed order on the substantive issues shall not be appealable to or reviewable by the director on the director's motion until the issuance of a proposed order on the reasonable litigation costs. If there is no such appeal or review within 30 days or 10 days, whichever is applicable, from the date of the proposed order on reasonable litigation costs, both the proposed order on the substantive issues and the proposed order on the reasonable litigation costs become the final orders of the department for purposes of judicial review or rehearing. On an appeal from, review of, or application for rehearing concerning the presiding officer's order, the director has all the power which the director would initially have had in making the decision; however, the director will only consider those issues or selected issues presented at the hearing before the presiding officer or any issues of fact or law raised independently by the presiding officer, including the propriety of and the authority for raising issues. The parties will be notified of those issues which will be considered by the director.

Notwithstanding the provisions of this rule, where a presiding officer other than the director issues an interlocutory decision or ruling which does not dispose of all the issues, except reasonable litigation costs, in the contested case proceeding, the party adversely affected by the interlocutory decision or ruling may apply to the director within 20 days (10 days for a revocation proceeding) of the date of issuance of the

interlocutory decision or ruling to grant an appeal in advance of the proposed decision. The application shall be served on the parties and the presiding officer. The party opposing the application shall file any resistance within 15 days of the service of the application unless, for good cause, the director extends the time for such filing. The director, in the exercise of discretion, may grant the application on finding that such interlocutory decision or ruling involves substantial rights and will materially affect the proposed decision and that a determination of its correctness before hearing on the merits will better serve the interests of justice. The order of the director granting the appeal may be on terms setting forth the course of proceedings on appeal, including advancing the appeal for prompt submission, and the order shall stay further proceedings below. The presiding officer, at the request of the director, shall promptly forward to the director all or a portion of the file or record in the contested case proceeding.

In the event of an appeal to or review of the proposed order by the director, the administrative hearings division shall be promptly notified of the appeal or review by the director. The administrative hearings division shall, upon such notice, promptly forward the record of the contested case proceeding and all other papers associated with the case to the director.

A decision by the director may reverse or modify any finding of fact if a preponderance of the evidence will support a determination to reverse or modify such a finding of fact, or may reverse or modify any conclusion of law that the director finds to be in error.

Orders will be issued within a reasonable time after termination of the hearing. Parties shall be promptly notified of each order by delivery to them of a copy of the order by personal service or certified mail, return receipt requested, except in the case of an order revoking a sales or use tax permit or a motor fuel license which may be delivered by ordinary mail.

A cross-appeal may be taken within the 30-day period for taking an appeal to the director of revenue or in any event within 5 days after the appeal to the director is taken. If a cross-appeal is taken from a revocation order pursuant to rule 701—7.55(17A), the cross-appeal may be taken within the 10-day period for taking an appeal to the director or in any event within 5 days after the appeal to the director is taken.

Upon issuance of a closing order or the proposed decision by a presiding officer other than the director, such presiding officer no longer has jurisdiction over the contested case. Thereafter, any further proceedings associated with or related to the contested case must occur before the director.

7.50(8) *Stays*. During the pendency of judicial review of the final contested case order of the department, the party seeking judicial review may file an application for a stay with the director. The application shall set forth the reasons in detail why the applicant is entitled to a stay and shall specifically address the following four factors:

a. The extent to which the applicant is likely to prevail when the court finally disposes of the matter;

b. The extent to which the applicant will suffer irreparable injury if the stay is not granted;

c. The extent to which the grant of a stay to the applicant will substantially harm the other parties to the proceedings; and

d. The extent to which the public interest relied on by the department is sufficient to justify the department's actions in the circumstances.

The director shall consider and balance the previously mentioned four factors and may consult with department personnel and the department's representatives in the judicial review proceeding. The director shall expeditiously grant or deny the stay.

7.50(9) *Expedited cases—when applicable.* In case a protest is filed where the case is not of precedential value and the parties desire a prompt resolution of the dispute, the department and the protester may agree to have the case designated as an expedited case.

a. Agreement. The department and the protester shall execute an agreement to have the case treated as an expedited case. In this case, discovery is waived. The provisions of this agreement shall constitute a waiver of the rights set forth in Iowa Code chapter 17A for contested case proceedings. Within 30 days of written notice to the clerk of the hearings section for the department sent by the parties stating that an agreement to expedite the case has been executed, the clerk of the hearings section for the department must transfer the protest file to the division of administrative hearings.

b. Finality of decision. A decision entered in an expedited case proceeding shall not be reviewed by the director, state board of tax review, or any other court, and shall not be treated as a precedent for any other case.

c. Discontinuance of proceedings. Any time prior to a decision's being rendered, the taxpayer or the department may request that expedited case proceedings be discontinued if there are reasonable grounds to believe that the issues in dispute would be of precedential value.

d. Procedure. Upon return of an executed agreement for this procedure, the department shall within 14 days file its answer to the protest. The case shall be docketed for hearing as promptly as the presiding officer can reasonably hear the matter.

7.50(10) *Burden of proof.* The burden of proof with respect to assessments or denials of refunds in contested case proceedings is as follows:

a. The department must carry the burden of proof by clear and convincing evidence as to the issue of fraud with intent to evade tax.

b. The burden of proof is on the department for any tax periods for which the assessment was not made within six years after the return became due, excluding any extension of time for filing such return, except where the department's assessment is the result of the final disposition of a matter between the taxpayer and the Internal Revenue Service or where the taxpayer and the department signed a waiver of the statute of limitations to assess.

c. The burden of proof is on the department as to any new matter or affirmative defense raised by the department. "New matter" means an adjustment not set forth in the computation of the tax in the assessment or refund denial, as distinguished from a new reason for the assessment or refund denial. "Affirmative defense" is one resting on facts not necessary to support the taxpayer's case.

d. In all instances where the burden of proof is not expressly placed upon the department in this subrule, the burden of proof is upon the protester.

7.50(11) *Costs.* A prevailing taxpayer in a contested case proceeding related to the determination, collection, or refund of a tax, penalty, or interest may be awarded reasonable litigation costs by the department incurred subsequent to the issuance of the notice of assessment or refund denial based upon the following:

a. The reasonable expenses of expert witnesses.

b. The reasonable costs of studies, reports, and tests.

c. The reasonable fees of independent attorneys or independent accountants retained by the taxpayer. No such award is authorized for accountants or attorneys who represent themselves or who are employees of the taxpayer.

d. An award for reasonable litigation costs shall not exceed $25,000 per case.

e. No award shall be made for any portion of the proceeding which has been unreasonably protracted by the taxpayer.

f. For purposes of this subrule, "prevailing taxpayer" means a taxpayer who establishes that the position of the department in the contested case proceeding was not substantially justified and who has substantially prevailed with respect to the amount in controversy, or has substantially prevailed with respect to the most significant issue or set of issues presented. If the position of the department in issuance of the assessment or refund denial was not substantially justified and if the matter is resolved or conceded before the contested case proceeding is commenced, there cannot be an award for reasonable litigation costs.

g. The definition of "prevailing taxpayer" is taken from the definition of "prevailing party" in 26 U.S.C. §7430. Therefore, federal cases determining whether the Internal Revenue Service's position was substantially justified will be considered in the determination of whether a taxpayer is entitled to an award of reasonable litigation costs to the extent that 26 U.S.C. §7430 is consistent with Iowa Code section 421.60(4).

h. The taxpayer has the burden of establishing the unreasonableness of the department's position.

i. Once a contested case has commenced, a concession by the department of its position or a settlement of the case either prior to the evidentiary hearing or any order issued does not, per se, either authorize an award of reasonable litigation costs or preclude such award.

j. If the department relied upon information provided or action conducted by federal, state, or local officials or law enforcement agencies with respect to the tax imposed by Iowa Code chapter 453B, an award for reasonable litigation costs shall not be made in a contested case proceeding involving the determination, collection, or refund of that tax.

k. The taxpayer who seeks an award of reasonable litigation costs must specifically request such award in the protest or it will not be considered.

l. A request for an award of reasonable litigation costs shall be held in abeyance until the concession or settlement of the contested case proceeding, or the issuance of a proposed order in the contested case proceeding, unless the parties agree otherwise.

m. At the hearing held for the purpose of deciding whether an award for reasonable litigation costs should be awarded, consideration shall be given to the following points:

(1) Whether the department's position was substantially justified;

(2) Whether the protester is the prevailing taxpayer;

(3) The burden is upon protester to establish how the alleged reasonable litigation costs were incurred. This requires a detailed accounting of the nature of each cost, the amount of each cost, and to whom the cost was paid or owed;

(4) Whether alleged litigation costs are reasonable or necessary;

(5) Whether protester has met its burden of demonstrating all of these points.

7.50(12) *Interlocutory appeals.* Upon written request of a party or on the director's own motion, the director may review an interlocutory order of the presiding officer. In determining whether to do so, the director shall weigh the extent to which granting the interlocutory appeal would expedite final resolution of the case and the extent to which review of that interlocutory order by the director at the time of the review of the proposed decision of the presiding officer would provide an adequate remedy. Any request for interlocutory review must be filed within 14 days of issuance of the challenged order, but no later than the time for compliance with the order or the date of hearing, whichever is first.

Interlocutory appeals do not apply to licensing.

7.50(13) *Consolidation and severance.*

a. Consolidation. The presiding officer may consolidate any or all matters at issue in two or more contested case proceedings where:

(1) The matters at issue involve common parties or common questions of fact or law;

(2) Consolidation would expedite and simplify consideration of the issues involved; and

(3) Consolidation would not adversely affect the rights of any of the parties to those proceedings.

b. Severance. The presiding officer may, for good cause shown, order any contested case proceedings or portions thereof severed.

Since stipulations are encouraged, it is expected and anticipated that the parties proceeding to a hearing will stipulate to evidence to the fullest extent to which complete or qualified agreement can be reached including all material facts that are not, or should not be, fairly in dispute.

Without the necessity of proceeding to an evidentiary hearing in a contested case, the parties may agree in writing to informally dispose of the case by stipulation, agreed settlement, consent order, or by another method agreed upon. If such informal disposition is utilized, the parties shall so indicate to the presiding officer that the case has been settled. Upon request, the presiding officer shall issue a closing order to reflect such a disposition. The contested case is terminated upon issuance of a closing order.

Unless otherwise precluded by law, the parties in a contested case proceeding may mutually agree to waive any provision under these sets of rules governing the contested case proceedings.

This rule is intended to implement Iowa Code sections 17A.15(3), 421.60, 422.57(1) and 452A.68.

701—7.51(17A) Record and transcript. The record in a contested case shall include:

1. All pleadings, motions and rulings;
2. All evidence received or considered and all other submissions;
3. A statement of all matters officially noticed;
4. All questions and offers of proof, objections, and rulings thereon;
5. All proposed findings and exceptions;

6. All orders of the presiding officer; and
7. The order of the director on appeal or review.

Oral hearings regarding proceedings on appeal to or considered on motion of the director which are recorded by mechanical means shall not be transcribed for the record of such appeal or review unless a party, by written notice, or the director, orally or in writing, requests such transcription. Such a request must be filed with the clerk of the hearings section for the department who will be responsible for making the transcript. A transcription will be made only of that portion of the oral hearing relevant to the appeal or review, if so requested, and no objection is made by any other party to the proceeding or the director. Upon request, the department shall provide a copy of the whole or any portion of the record at cost. The cost of preparing a copy of the record or of transcribing the hearing record shall be paid by the requesting party.

Parties who request that a hearing be recorded by certified shorthand reporters rather than by electronic means shall bear the cost of that recordation, unless otherwise provided by law.

Upon issuance of a proposed decision which leaves no issues open for further consideration or upon issuance of a closing order, the administrative hearings division shall promptly forward the record of a contested case proceeding to the director. However, the administrative hearings division may keep the tapes and any evidentiary proceeding in case a transcript of the proceeding is required and, if one is required, the administrative hearings division shall make the transcription and promptly forward the tapes and the transcription to the director.

701—7.52(17A) Rehearing. Any party to a contested case may file an application with the director for a rehearing in the contested case, stating the specific grounds therefor and the relief sought. The application must be filed within 20 days after the final order is issued. See subrule 7.50(7) as to when a proposed order becomes a final order. A copy of such application shall be timely mailed by the applicant to all parties in conformity with rule 701—7.53(17A). The director shall have 20 days from the filing of the application to grant or deny the rehearing. If the application is granted, a notice will be served on the parties stating the time and place of the rehearing. An application for rehearing shall be deemed denied if not granted by the director within 20 days after filing.

The application for rehearing which is filed shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____ (state taxpayer's name and address and designate type of proceeding, e.g., income tax refund claim).	APPLICATION FOR REHEARING DOCKET NO._____

The application for rehearing shall substantially state in separate numbered paragraphs the following:

1. Clear and concise statements of the reasons for requesting a rehearing and each and every error which the party alleges to have been committed during the contested case proceedings;
2. Clear and concise statements of all relevant facts upon which the party relies;
3. Reference to any particular statute or statutes and any rule or rules involved;
4. The signature of the party or that of the party's representative, the address of the party or the party's representative, and the telephone number of the party or the party's representative.

No applications for rehearing shall be filed with or entertained by an administrative law judge.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.53(17A) Service. All papers or documents required by 701—Chapter 7 to be filed with the department or the presiding officer and served upon the opposing party or other person shall be served by ordinary mail unless another rule specifically refers to another method. All notices required by

701—Chapter 7 to be served on parties or persons by the department or presiding officer shall be served by ordinary mail unless another rule specifically refers to another method.

This rule is intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202.

701—7.54(17A) Ex parte communications and disqualification.

7.54(1) *Ex parte communication.* A party that has knowledge of a prohibited communication by any party or presiding officer should file a copy of the written prohibited communication or a written summary of the prohibited oral communication with the clerk of the hearings section for the department. The clerk of the hearings section for the department is to transfer the filed copy of the prohibited communication to the presiding officer.

a. Prohibited communications. Unless required for the disposition of ex parte matters specifically authorized by statute, following issuance of the notice of hearing, there shall be no communication, directly or indirectly, between the presiding officer and any party or representative of any party or any other person with a direct or indirect interest in such case in connection with any issue of fact or law in the case except upon notice and opportunity for all parties to participate. This does not prohibit persons jointly assigned such tasks from communicating with each other. Nothing in this provision is intended to preclude the presiding officer from communicating with members of the department or seeking the advice or help of persons other than those with a personal interest in, or those engaged in personally investigating as defined in this rule, prosecuting, or advocating in, either the case under consideration or a pending factually related case involving the same parties as long as those persons do not directly or indirectly communicate to the presiding officer any ex parte communications they have received of a type that the presiding officer would be prohibited from receiving or that furnish, augment, diminish, or modify the evidence in the record.

Prohibitions on ex parte communications commence with the issuance of the notice of hearing in a contested case and continue for as long as the case is pending.

b. "Ex parte" communication defined. Written, oral or other forms of communication are "ex parte" if made without notice and opportunity for all parties to participate.

c. How to avoid prohibited communications. To avoid prohibited ex parte communications, notice must be given in a manner reasonably calculated to give all parties a fair opportunity to participate. Notice of written communications shall be provided in compliance with rules in this division and may be supplemented by telephone, facsimile, electronic mail or other means of notification. Where permitted, oral communications may be initiated through conference telephone calls, including all parties or their representatives.

d. Joint presiding officers. Persons who jointly act as presiding officer in a pending contested case may communicate with each other without notice or opportunity for parties to participate.

e. Advice to presiding officer. Persons may be present in deliberations or otherwise advise the presiding officer without notice or opportunity for parties to participate as long as they are not disqualified from participating in the making of a proposed or final decision under any provision of law and they comply with the rules in this division.

f. Procedural communications. Communications with the presiding officer involving uncontested scheduling or procedural matters do not require notice or opportunity for parties to participate. Parties should notify other parties prior to initiating such contact with the presiding officer when feasible, and shall notify other parties when seeking to continue hearings or other deadlines.

g. Disclosure of prohibited communications. A presiding officer who receives a prohibited ex parte communication during the pendency of a contested case must initially determine if the effect of the communication is so prejudicial that the presiding officer should be disqualified. If the presiding officer determines that disqualification is warranted, a copy of any prohibited written communication, all written responses to the communication, a written summary stating the substance of any prohibited oral or other communication not available in written form for disclosure, all responses made, and the identity of each person from whom the presiding officer received a prohibited ex parte communication, shall be submitted for inclusion in the record under seal by protective order. If the presiding officer determines

that disqualification is not warranted, such documents shall be submitted for inclusion in the record and served on all parties. Any party desiring to rebut the prohibited communication must be allowed the opportunity to do so upon written request filed within ten days after notice of the communication.

h. Disclosure by presiding officer. Promptly after being assigned to serve as presiding officer at any stage in a contested case proceeding, a presiding officer shall disclose to all parties material factual information received through ex parte communication prior to such assignment unless the factual information has already been or shortly will be disclosed pursuant to Iowa Code section 17A.13(2) or through discovery. Factual information contained in an investigative report or similar document need not be separately disclosed by the presiding officer as long as such documents have been or will shortly be provided to the parties.

i. Sanction. The presiding officer may render a proposed or final decision imposing appropriate sanctions for violations of this rule, including default, a decision against the offending party, censure, suspension, or revocation of the privilege to practice before the department or the administrative hearings division. Violation of ex parte communication prohibitions by department personnel or their representatives shall be reported to the clerk of the hearings section for the department for possible sanctions including censure, suspension, dismissal, or other disciplinary action.

7.54(2) *Disqualification of a presiding officer.* Request for disqualification of a presiding officer must be filed in the form of a motion supported by an affidavit asserting an appropriate ground for disqualification. A substitute presiding officer may be appointed by the division of administrative hearings pursuant to 1998 Iowa Acts, chapter 1202, section 15, if the disqualified presiding officer is an administrative law judge. If the disqualified presiding officer is the director, the governor must appoint a substitute presiding officer.

a. Grounds for disqualification. A presiding officer or other person shall withdraw from participation in the making of any proposed or final decision in a contested case if that person:

(1) Has a personal bias or prejudice concerning a party or a representative of a party;

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

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

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

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

(6) Has a spouse or relative within the third degree of relationship that:

1. Is a party to the case, or an officer, director or trustee of a party;
2. Is a lawyer in the case;
3. Is known to have an interest that could be substantially affected by the outcome of the case; or
4. Is likely to be a material witness in the case; or

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

b. "Personally investigated" means taking affirmative steps to interview witnesses directly or to obtain documents or other information directly. The term "personally investigated" does not include general direction and supervision of assigned investigators, unsolicited receipt of information which is relayed to assigned investigators, review of another person's investigative work product in the course of determining whether there is probable cause to initiate a proceeding, or exposure to factual information while performing other department functions, including fact gathering for purposes other than investigation of the matter which culminates in a contested case. Factual information relevant to the merits of a contested case received by a person who later serves as presiding officer in that case shall be disclosed if required by 1998 Iowa Acts, chapter 1202, section 19(3), and these rules.

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

d. Motion asserting disqualification. If a party asserts disqualification on any appropriate ground, the party shall file a motion supported by an affidavit pursuant to 1998 Iowa Acts, chapter 1202, section 19(7). The motion must be filed as soon as practicable after the reason alleged in the motion becomes known to the party. If, during the course of the hearing, a party first becomes aware of evidence of bias or other grounds for disqualification, the party may move for disqualification but must establish the grounds by the introduction of evidence into the record.

If the presiding officer determines that disqualification is appropriate, the presiding officer or other person shall withdraw. If the presiding officer determines that withdrawal is not required, the presiding officer shall enter an order to that effect. A party asserting disqualification may seek an interlocutory appeal and seek a stay as provided under this division.

701—7.55(17A) Licenses.

7.55(1) *Denial of license, refusal to renew license.* When the department is required by constitution or statute to provide notice and an opportunity for an evidentiary hearing prior to the refusal or denial of a license, a notice, as prescribed in 701—7.47(17A), shall be served by the department upon the licensee or applicant. Prior to the refusal or denial of a license, the department shall give 30 days' written notice to the applicant or licensee in which to appear at a hearing to show cause why a license should not be refused or denied. In addition to the requirements of 701—7.47(17A) the notice shall contain a statement of facts or conduct and the provisions of law which warrant the denial of the license or the refusal to renew a license. If the licensee so desires, the licensee may file a petition as provided in subrule 7.55(3) with the presiding officer within 30 days prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this division governing contested case proceedings shall apply.

When a licensee has made timely and sufficient application for the renewal of a license or a new license with reference to any activity of a continuing nature, the existing license does not expire until the application has been finally determined by the department, and in case the application is denied or the terms of the new license limited, until the last date for seeking judicial review of the department's order or a later date fixed by order of the department or the reviewing court. See 195—subrule 20.4(1) regarding gambling license applications.

7.55(2) *Revocation of license.* The department shall not revoke, suspend, annul or withdraw any license until written notice is served by personal service or restricted certified mail pursuant to 701—7.47(17A) within the time prescribed by the applicable statute and the licensee whose license is to be revoked, suspended, annulled or withdrawn, is given an opportunity to show at an evidentiary hearing conducted pursuant to the rules governing contested case proceedings in this chapter compliance with all lawful requirements for the retention of the license. However, in the case of the revocation, suspension, annulment, or withdrawal of a sales or use tax permit, written notice will be served pursuant to 701—7.47(17A) only if the permit holder requests that this be done following notification, by ordinary mail, of the director's intent to revoke, suspend, annul, or withdraw the permit. In addition to the requirements of 701—7.47(17A) the notice shall contain a statement of facts or conduct and the provisions of law which warrant the revocation, suspension, annulment, or withdrawal of the license. A licensee whose license may be revoked, suspended, annulled, or withdrawn, may file a petition as provided in subrule 7.55(3) with the clerk of the hearings section for the department prior to the hearing. The department may, in its discretion, file an answer to a petition filed by the licensee prior to the hearing. Thereafter, the rules contained in this division governing contested case proceedings shall apply.

Notwithstanding the above, if the department finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in an order to the licensee, summary

suspension of a license shall be ordered pending proceedings for revocation as provided herein. These proceedings shall be promptly instituted and determined. When a summary suspension as provided herein is ordered, a notice of the time, place and nature of the evidentiary hearing shall be attached to the order.

7.55(3) *Petition.* When a person desires to file a petition as provided in subrules 7.55(1) and 7.55(2), the petition to be filed shall contain a caption in the following form:

BEFORE THE DEPARTMENT OF REVENUE
HOOVER STATE OFFICE BUILDING
DES MOINES, IOWA

IN THE MATTER OF _____ (state taxpayer's name, and address and type of license).	PETITION DOCKET NO._____ (filled in by Department)

The petition shall substantially state in separate numbered paragraphs the following:

1. The full name and address of the petitioner;
2. Reference to the type of license and the relevant statutory authority;
3. Clear, concise and complete statements of all relevant facts showing why petitioner's license should not be revoked, refused, or denied;
4. Whether a similar license has previously been issued to or held by petitioner or revoked and if revoked the reasons therefor; and
5. The signature of the petitioner or petitioner's representative, the address of petitioner and of petitioner's representative, and the telephone number of petitioner or petitioner's representative.

701—7.56(17A) Declaratory order—in general. Any oral or written advice or opinion rendered to members of the public by department personnel not pursuant to a petition for declaratory order is not binding upon the department. However, department personnel, including field personnel, ordinarily will discuss substantive tax issues with members of the public or their representatives prior to the receipt of a petition for a declaratory order, but such oral or written opinions or advice are not binding on the department. This should not be construed as preventing members of the public or their representatives from inquiring whether the department will issue a declaratory order on a particular question. In these cases, however, the name of the taxpayer shall be disclosed. The department will also discuss questions relating to certain procedural matters as, for example, submitting a request for a declaratory order or submitting a petition to initiate rule-making procedures. Members of the public may, of course, seek oral technical assistance from a departmental employee in regard to the proper preparation of a return or report required to be filed with the department. Such oral advice is advisory only and the department is not bound to recognize it in the examination of the return, report or records.

7.56(1) *Petition for declaratory order.* Any person may file a petition with the Clerk of the Hearings Section for the Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319, seeking a declaratory order as to the applicability to specified circumstances of a statute, rule, or order within the primary jurisdiction of the department. A petition is deemed filed when it is received by the clerk of the hearings section for the department. The clerk of the hearings section for the department shall provide the petitioner with a file-stamped copy of the petition if the petitioner provides the clerk of the hearings section for the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Petitioner) for a Declaratory Order on (Cite provisions of law involved).	PETITION FOR DECLARATORY ORDER Docket No._____

The petition must provide the following information:

a. A clear and concise statement of all relevant facts on which the order is requested;

b. A citation and the relevant language of the specific statutes, rules, policies, decisions, or orders, whose applicability is questioned, and any other relevant law;

c. The questions petitioner wants answered, stated clearly and concisely;

d. The answers to the questions desired by the petitioner and a summary of the reasons urged by the petitioner in support of those answers;

e. The reasons for requesting the declaratory order and disclosure of the petitioner's interest in the outcome;

f. A statement indicating whether the petitioner is currently a party to another proceeding involving the questions at issue and whether, to the petitioner's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity;

g. The names and addresses of other persons, or a description of any class of persons, known by petitioner to be affected by, or interested in, the questions presented in the petition;

h. Any request by petitioner for a meeting provided for by this rule; and

i. Whether the petitioner is presently under audit by the department.

The petition must be dated and signed by the petitioner or the petitioner's representative. It must also include the name, mailing address, and telephone number of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

7.56(2) *Notice of petition.* Within 15 days after receipt of a petition for a declaratory order, the clerk of the hearings section for the department shall give notice of the petition to all persons not served by the petitioner to whom notice is required by any provision of law. The clerk of the hearings section for the department may also give notice to any other persons.

7.56(3) *Intervention.*

a. Persons who qualify under any applicable provision of law as an intervenor and who file a petition for intervention within 20 days of the filing of a petition for declaratory order, shall be allowed to intervene in a proceeding for a declaratory order.

b. Any person who files a petition for intervention at any time prior to the issuance of an order may be allowed to intervene in a proceeding for a declaratory order at the discretion of the department.

c. A petition for intervention shall be filed with the Clerk of the Hearings Section for the Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319. Such a petition is deemed filed when it is received by the clerk of the hearings section for the department. The clerk of the hearings section for the department will provide the petitioner with a file-stamped copy of the petition for intervention if the petitioner provides an extra copy for this purpose. A petition for intervention must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Original Petitioner) for a Declaratory Order on (Cite provisions of law cited in original Petition).	}	PETITION FOR INTERVENTION Docket No._____

The petition for intervention must provide the following information:

(1) Facts supporting the intervenor's standing and qualifications for intervention;

(2) The answers urged by the intervenor to the question or questions presented and a summary of the reasons urged in support of those answers;

(3) Reasons for requesting intervention and disclosure of the intervenor's interest in the outcome;

(4) A statement indicating whether the intervenor is currently a party to any proceeding involving the questions at issue and whether, to the intervenor's knowledge, those questions have been decided by, are pending determination by, or are under investigation by, any governmental entity;

(5) The names and addresses of any additional persons, or a description of any additional class of persons, known by the intervenor to be affected by, or interested in, the questions presented;

(6) Whether the intervenor consents to be bound by the determination of the matters presented in the declaratory order proceeding;

(7) Whether the intervenor is presently under audit by the department; and

(8) Consent of the intervenor to be bound by the declaratory order.

The petition must be dated and signed by the intervenor or the intervenor's representative. It must also include the name, mailing address, and telephone number of the intervenor and intervenor's representative, and a statement indicating the person to whom communications should be directed.

For a petition for intervention to be allowed, the petitioner must have consented to be bound by the declaratory order and the petitioner must have standing regarding the issues raised in the petition for declaratory order. The petition for intervention must not correct or raise any additional facts that are in the petition for declaratory order. To have standing, the intervenor must have a legally protectible and tangible interest at stake in the petition for declaratory order under consideration by the director for which the party wishes to petition to intervene. Black's Law Dictionary, Centennial Edition, p. 1405, citing, Guidry v. Roberts, 331 So. 44, 50 (La.App.). Based on Iowa case law, the department may refuse to entertain a petition from one whose rights will not be invaded or infringed. Bowers v. Bailey 237 Iowa 295, 21 N.W.2d 773 (1946). The department may, by rule, impose a requirement of standing upon those that seek a declaratory order at least to the extent of requiring that they be potentially aggrieved or adversely affected by the department action or failure to act. Bonfield, "The Iowa Administrative Procedure Act, Background, Construction, Applicability and Public Access to Agency Law, The Rule-making Process," 60 Iowa Law Review 731, 805 (1975). The department adopts this requirement of standing for those seeking a petition for a declaratory order and those seeking to intervene in a petition for a declaratory order.

An association or a representative group is not considered to be an entity qualifying for filing a petition requesting a declaratory order on behalf of all of the association or group members. Each member of an association may not be similarly situated or represented by the factual scenario set forth in such a petition.

If a party seeks to have an issue determined by declaratory order, but the facts are different from a petition for declaratory order that is currently under consideration by the director, the interested party should not petition as an intervenor in the petition for declaratory order currently under the director's consideration. Instead, the party should file a separate petition for a declaratory order and the petition should include all of the relevant facts. The director may deny a petition for intervention without denying the underlying petition for declaratory order that is involved.

7.56(4) *Briefs.* The petitioner or any intervenor may file a brief in support of the position urged. The department may request a brief from the petitioner, any intervenor, or any other person concerning the questions raised in the petition.

7.56(5) *Inquiries.* Inquiries concerning the status of a declaratory order proceeding may be made to Administrator of the Compliance Division, Department of Revenue, Fourth Floor, Hoover State Office Building, Des Moines, Iowa 50319.

7.56(6) *Service and filing of petitions and other papers.*

a. When service required. Except where otherwise provided by law, every petition for declaratory order, petition for intervention, brief, or other paper filed in a proceeding for a declaratory order shall be served upon each of the parties of record to the proceeding, and on all other persons identified in the petition for declaratory order or petition for intervention as affected by or interested in the questions presented, simultaneously with their filing. The party filing a document is responsible for service on all parties and other affected or interested persons.

b. Filing—when required. All petitions for declaratory orders, petitions for intervention, briefs, or other papers in a proceeding for a declaratory order, shall be filed with Clerk of the Hearings Section for the Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. All petitions, briefs, or other papers that are required to be served upon a party shall be filed simultaneously with the department.

c. Method of service, time of filing, and proof of mailing. Method of service, time of filing, and proof of mailing shall be as provided in 701—7.41(17A) and 701—7.53(17A).

7.56(7) *Department consideration.* Upon request by petitioner in the petition, the department may schedule a brief and informal meeting between the original petitioner, all intervenors, and the department, a member of the department, or a member of the staff of the department, to discuss the questions raised. The department may solicit comments or information from any person on the questions raised. Also, comments or information on the questions raised may be submitted to the department by any person.

7.56(8) *Action on petition.*

a. Within the time allowed by 1998 Iowa Acts, chapter 1202, section 13(5), after receipt of a petition for a declaratory order, the director shall take action on the petition as required by 1998 Iowa Acts, chapter 1202, section 13(5).

b. The date of issuance of an order or of a refusal to issue an order is as defined in 701—7.37(17A).

7.56(9) *Refusal to issue order.*

a. The department shall not issue a declaratory order where prohibited by 1998 Iowa Acts, chapter 1202, section 13(1), and may refuse to issue a declaratory order on some or all questions raised for the following reasons:

(1) The petition does not substantially comply with the required form;

(2) The petition does not contain facts sufficient to demonstrate that the petitioner will be aggrieved or adversely affected by the failure of the department to issue an order;

(3) The department does not have jurisdiction over the questions presented in the petition;

(4) The questions presented by the petition are also presented in a current rule making, contested case, or other department or judicial proceeding, that may definitively resolve them;

(5) The questions presented by the petition would more properly be resolved in a different type of proceeding or by another body with jurisdiction over the matter;

(6) The facts or questions presented in the petition are unclear, overbroad, insufficient, or otherwise inappropriate as a basis upon which to issue an order;

(7) There is no need to issue an order because the questions raised in the petition have been settled due to a change in circumstances;

(8) The petition is not based upon facts calculated to aid in the planning of future conduct but is, instead, based solely upon prior conduct, in an effort to establish the effect of that conduct or to challenge a department decision already made;

(9) The petition requests a declaratory order that would necessarily determine the legal rights, duties, or responsibilities of other persons who have not joined in the petition, intervened separately, or filed a similar petition and whose position on the questions presented may fairly be presumed to be adverse to that of petitioner;

(10) The petitioner requests the department to determine whether a statute is unconstitutional on its face; or

(11) The petition requests a declaratory order on an issue presently under investigation or audit or in rule-making proceedings or in litigation in a contested case or court proceedings.

b. A refusal to issue a declaratory order must indicate the specific grounds for the refusal and constitutes final agency action on the petition.

c. Refusal to issue a declaratory order pursuant to this provision does not preclude the filing of a new petition that seeks to eliminate the grounds for the department's refusal to issue an order.

7.56(10) *Contents of declaratory order—effective date.* In addition to the order itself, a declaratory order must contain the date of its issuance, the name of petitioner and all intervenors, the specific statutes, rules, policies, decisions, or orders involved, the particular facts upon which it is based, and the reasons for its conclusion.

A declaratory order is effective on the date of issuance.

7.56(11) *Copies of orders.* A copy of all orders issued in response to a petition for a declaratory order shall be mailed promptly to the original petitioner and all intervenors.

7.56(12) *Effect of a declaratory order.* A declaratory order has the same status and binding effect as a final order issued in a contested case proceeding. A declaratory order is binding on the department, the

petitioner, and any intervenors. As to all other persons, a declaratory order serves only as precedent and is not binding on the department. The issuance of a declaratory order constitutes final department action on the petition. A declaratory order, once issued, will not be withdrawn at the request of the petitioner.

7.56(13) *Prejudice or no consent.* The department will not issue a declaratory order that would substantially prejudice the rights of a person who would be a necessary party and who does not consent in writing to the determination of the matter by a declaratory order proceeding.

701—7.57(17A) Department procedure for rule making.

7.57(1) The department hereby adopts and incorporates by reference the following Uniform Rules on Agency Procedure for Rule Making, which are printed in the first volume of the Iowa Administrative Code, with the additions, changes, and deletions to those rules listed below:

X.2(17A) Advice on possible rules before notice of proposed rule adoption.

X.4(1) Notice of proposed rule making—contents.

X.4(3) Copies of notices. In addition to the text of this subrule, the department adds that the payment for the subscription and the subscription term is one year.

X.5(17A) Public participation. In addition to the text of this rule, the department also adds that written submissions should be submitted to the coadministrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. Also, any requests for special requirements concerning accessibility are to be made to the Clerk of the Hearings Section, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319, telephone (515)281-7081;

X.6(17A) Regulatory analysis. In addition to the text of this rule, the department also adds that small businesses or organizations of small businesses may register on the department's small business impact list by making a written application to the Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319;

X.7(17A,25B) Fiscal impact statement;

X.8(17A) Time and manner of rule adoption;

X.9(17A) Variance between adopted rule and published notice of proposed rule adoption; and

X.10(17A) Exemptions from public rule-making procedures. In addition to the text of this rule, the department also adds that exempt categories are generally limited to rules for nonsubstantive changes to a rule, such as rules for correcting grammar, spelling or punctuation in an existing or proposed rule.

X.11(17A) Concise statement of reasons. In addition to the text of this rule, the department also adds that a request for a concise statement of reasons for a rule must be submitted to the Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319.

X.12(1) Contents, style and form of rule—contents;

X.12(4) Contents, style and form—style and form;

X.14(17A) Filing of rules;

X.15(17A) Effectiveness of rules prior to publication;

X.16(17A) General statement of policy; and

X.17(17A) Review by agency of rules.

7.57(2) The department hereby states that the following cited Uniform Rules on Agency Procedure for Rule Making are not adopted by the department:

X.1(17A) Applicability;

X.3(17A) Public rule-making docket;

X.4(2) Notice of proposed rule making—incorporated by reference;

X.12(2) Contents, style, and form of rule—incorporation by reference;

X.12(3) Contents, style and form of rule—references to materials not published in full; and

X.13(17A) Agency rule-making record.

701—7.58(17A) Public inquiries on rule making and the rule-making records. The department maintains records of information obtained and all actions taken and criticisms received regarding any

rule within the past five years. The department also keeps a record of the status of every rule within the rule-making procedure. Inquiries concerning the status of rule making may be made by contacting the Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319. For additional information regarding criticism of rules see 701—7.59(17A).

701—7.59(17A) Criticism of rules. The Administrator of the Compliance Division, Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50319, is designated as the office where interested persons may submit by electronic means or by mail criticisms, requests for waivers, or comments regarding a rule. A criticism of a specific rule must be more than a mere lack of understanding of a rule or a dislike regarding the rule. To constitute a criticism of a rule, the criticism must be in writing, indicate it is a criticism of a specific rule, and have a valid legal basis for support. All requests for waivers, comments, or criticisms received on any rule will be kept in a separate record for a period of five years by the department.

These rules are intended to implement Iowa Code chapter 17A as amended by 1998 Iowa Acts, chapter 1202, and Iowa Code section 421.60.

DIVISION III
WAIVER OR VARIANCE

701—7.60(78GA,HF2206) Waiver or variance of certain department rules. All discretionary rules or discretionary provisions in a rule over which the department has jurisdiction, in whole or in part, may be subject to waiver or variance. See subrules 7.60(3) and 7.60(4).

7.60(1) *Definitions.* The following terms apply to the interpretation and application of this rule:

"Discretionary rule" or *"discretionary provisions in a rule"* means rules or provisions in rules resulting from a delegation by the legislature to the department to create a binding rule to govern a given issue or area. The department is not interpreting any statutory provision of the law promulgated by the legislature in a discretionary rule. Instead, a discretionary rule is authorized by the legislature when the legislature has delegated the creation of binding rules to the department and the contents of such rules are at the discretion of the department. A rule that contains both discretionary and interpretive provisions is deemed to be a discretionary rule to the extent of the discretionary provisions in the rule.

"Interpretive rules" or *"interpretive provisions in rules"* means rules or provisions in rules which define the meaning of a statute or other provision of law or precedent where the department does not possess the delegated authority to bind the courts to any extent with its definition.

"Waiver or variance" means an agency action which suspends, in whole or in part, the requirements or provisions of a rule as applied to an identified person on the basis of the particular circumstances of that person.

7.60(2) *Scope of rule.* This rule creates generally applicable standards and a generally applicable process for granting individual waivers or variances from the discretionary rules or discretionary provisions in rules adopted by the department in situations where no other specifically applicable law provides for waivers or variances. To the extent another more specific provision of law purports to govern the issuance of a waiver or variance from a particular rule, the more specific waiver or variance provision shall supersede this rule with respect to any waiver or variance from that rule.

The waiver or variance provisions set forth in this rule do not apply to rules over which the department does not have jurisdiction or when issuance of the waiver or variance would be inconsistent with any applicable statute, constitutional provision or other provision of law.

7.60(3) *Applicability of this rule.* This rule applies only to waiver or variance of those departmental rules that are within the exclusive rule-making authority of the department. This rule shall not apply to interpretive rules that merely interpret or construe the meaning of a statute, or other provision of law or precedent, if the department does not possess statutory authority to bind a court, to any extent, with its interpretation or construction. Thus, this waiver or variance rule applies to discretionary rules and discretionary provisions in rules, and not to interpretive rules.

The application of this rule is strictly limited to petitions for waiver or variance filed outside of a contested case proceeding. Petitions for waiver or variance from a discretionary rule or discretionary provisions in rules filed after the commencement of a contested case as provided in 701—7.47(17A) will be treated as an issue of the contested case to be determined by the presiding officer of the contested case.

7.60(4) *Authority to grant a waiver or variance.* The director may not issue a waiver or variance under this rule unless:

a. The legislature has delegated authority sufficient to justify the action; and

b. The waiver or variance is consistent with statutes and other provisions of law. No waiver or variance from any mandatory requirement imposed by statute may be granted under this rule.

7.60(5) *Criteria for waiver or variance.* The director may, in the director's sole discretion, issue an order in response to a petition, granting a waiver or variance from a discretionary rule or a discretionary provision in a rule adopted by the department, in whole or in part, as applied to the circumstances of a specified person, if the director finds that the waiver or variance is consistent with subrules 7.60(3) and 7.60(4), and if all of the following criteria are also met:

a. The waiver or variance would not prejudice the substantial legal rights of any person;

b. The rule or provisions of the rule are not specifically mandated by statute or another provision of law;

c. The application of the rule or rule provision would result in an undue hardship or injustice to the petitioner; and

d. Substantially equal protection of public health, safety, and welfare will be afforded by means other than that prescribed in the rule or rule provision for which the waiver or variance is requested.

7.60(6) *Director's discretion.* The final decision to grant or deny a waiver or variance shall be vested in the director of revenue. This decision shall be made at the sole discretion of the director based upon consideration of relevant facts.

7.60(7) *Burden of persuasion.* The burden of persuasion shall be on the petitioner to demonstrate by clear and convincing evidence that the director should exercise discretion to grant the petitioner a waiver or variance based upon the criteria contained in subrule 7.60(5).

7.60(8) *Contents of petition.* A petition for waiver or variance must be in the following format:

Iowa Department of Revenue

Name of Petitioner	*	Petition for
Address of Petitioner	*	Waiver
Type of Tax at Issue	*	Docket No._____

A petition for waiver or variance must contain all of the following, where applicable and known to the petitioner:

a. The name, address, telephone number, and case number or state identification number of the person or entity for whom a waiver or variance is being requested;

b. A description and citation of the specific rule or rule provisions from which a waiver or variance is being requested;

c. The specific waiver or variance requested, including a description of the precise scope and operative period for which the petitioner wants the waiver or variance to extend;

d. The relevant facts that the petitioner believes would justify a waiver or variance. This statement shall include a signed statement from the petitioner attesting to the accuracy of the facts represented in the petition, and a statement of reasons that the petitioner believes will justify a waiver or variance;

e. A complete history of any prior contacts between the petitioner and the department relating to the activity affected by the proposed waiver or variance, including audits, notices of assessment, refund claims, contested case hearings, or investigative reports relating to the activity within the last five years;

f. Any information known to the petitioner relating to the department's treatment of similar cases;

g. The name, address, and telephone number of any public agency or political subdivision which might be affected by the grant of a waiver or variance;

h. The name, address, and telephone number of any person or entity who would be adversely affected by the granting of the waiver or variance;

i. The name, address, and telephone number of any person with knowledge of the relevant facts relating to the proposed waiver or variance;

j. Signed releases of information authorizing persons with knowledge of relevant facts to furnish the department with information relating to the waiver or variance;

k. If the petitioner seeks to have identifying details deleted, which deletion is authorized by statute, such details must be listed with the statutory authority for the deletion; and

l. Signature by the petitioner at the conclusion of the petition attesting to the accuracy and truthfulness of the information set forth in the petition.

7.60(9) *Filing of petition.* A petition for waiver or variance must be filed with the clerk of the hearings section for the Department of Revenue, Hoover State Office Building, Fourth Floor, Des Moines, Iowa 50309.

7.60(10) *Additional information.* Prior to issuing an order granting or denying a waiver or variance, the director may request additional information from the petitioner relating to the petition and surrounding circumstances. The director may, on the director's own motion, or at the petitioner's request, schedule a telephonic or in-person meeting between the petitioner or the petitioner's representative, or both, and the director to discuss the petition and surrounding circumstances.

7.60(11) *Notice of petition for waiver or variance.* The petitioner shall provide, within 30 days of filing the petition for waiver or variance, a notice consisting of a concise summary of the contents of the petition for waiver or variance and stating that the petition is pending. Such notice shall be mailed by the petitioner to all persons entitled to such notice. Such persons to whom notice must be mailed include, but are not limited to, the director and all parties to the petition for waiver or variance, or the parties' representatives. The petitioner must then file written notice with the clerk of the hearings section for the department (address indicated above) attesting that the notice has been mailed. The names, addresses and telephone numbers of the persons to whom the notices were mailed shall be included in the filed written notice. The department has the discretion to give such notice to persons other than those persons notified by the petitioner.

7.60(12) *Ruling on a petition for waiver or variance.* An order granting or denying a waiver or variance must conform to the following:

a. An order granting or denying a waiver or variance shall be in writing and shall contain a reference to the particular person and rule or rule provision to which the order pertains, a statement of the relevant facts and reasons upon which the action is based and a description of the narrow and precise scope and operative time period of a waiver or variance, if one is issued.

b. If a petition requested the deletion of identifying details, then the order must either redact the details prior to the placement of the order in the public record file referenced in subrule 7.60(17) or set forth the grounds for denying the deletion of identifying details as requested.

c. Conditions. The director may condition the grant of a waiver or variance on any conditions which the director deems to be reasonable and appropriate in order to protect the public health, safety and welfare.

7.60(13) *Time period for waiver or variance; extension.* Unless otherwise provided, an order granting a petition for waiver or variance will be effective for 12 months from the date the order granting the waiver or variance is issued. Renewal of a granted waiver or variance is not automatic. To renew the waiver or variance beyond the 12-month period, the petitioner must file a new petition requesting a waiver or variance. The renewal petition will be governed by the provisions in this rule and must be filed prior to the expiration date of the previously issued waiver or variance or extension of waiver or variance. Even if the order granting the waiver or variance was issued in a contested case proceeding, any request for an extension shall be filed with and acted upon by the director. However, renewal petitions must request an extension of a previously issued waiver or variance. Granting the extension of the waiver or variance is at the director's sole discretion and must be based upon whether the factors set out in subrules 7.60(4) and 7.60(5) remain valid.

7.60(14) *Time for ruling.* The director shall grant or deny a petition for waiver or variance as soon as practicable but, in any event, shall do so within 120 days of its receipt, unless the petitioner agrees in writing to a later date or the director indicates in a written order that it is impracticable to issue the order within the 120-day period.

7.60(15) *When deemed denied.* Failure of the director to grant or deny a waiver or variance within the 120-day or the extended time period shall be deemed a denial of that petition.

7.60(16) *Service of orders.* Within seven days of its issuance, any order issued under this rule shall be transmitted to the petitioner or the person to whom the order pertains, and to any other person entitled to such notice by any provision of law.

7.60(17) *Record keeping.* The department is required to maintain a record of all petitions for waiver or variance and rulings granting or denying petitions for waiver or variance.

a. Petitions for waiver or variance. The department shall maintain a record of all petitions for waiver or variance available for public inspection. Such records will be indexed and filed and made available for public inspection at the clerk of the hearings section for the department at the address previously set forth in subrule 7.60(9).

b. Report of orders granting or denying a waiver or variance. All orders granting or denying a waiver or variance shall be summarized in a semiannual report to be drafted by the department and submitted to the administrative rules coordinator and the administrative rules review committee.

7.60(18) *Cancellation of waiver or variance.* A waiver or variance issued pursuant to this rule may be withdrawn, canceled, or modified if, after appropriate notice, the director issues an order finding any of the following:

a. The person who obtained the waiver or variance order withheld or misrepresented material facts relevant to the propriety or desirability of the waiver or variance; or

b. The alternative means for ensuring that public health, safety, and welfare will be adequately protected after issuance of the waiver or variance order have been demonstrated to be insufficient, and no other means exist to protect the substantial legal rights of any person; or

c. The person who obtained the waiver or variance has failed to comply with all of the conditions in the waiver or variance order.

7.60(19) *Violations.* A violation of a condition in a waiver or variance order shall be treated as a violation of the particular rule or rule provision for which the waiver or variance was granted. As a result, the recipient of a waiver or variance under this rule who violates a condition of the waiver or variance may be subject to the same remedies or penalties as a person who violates the rule or rule provision at issue.

7.60(20) *Defense.* After an order granting a waiver or variance is issued, the order shall constitute a defense, within the terms and the specific facts indicated therein, for the person to whom the order pertains in any proceeding in which the rule in question is sought to be invoked, unless subrules 7.60(18) and 7.60(19) are applicable.

7.60(21) *Hearing and appeals.* Appeals from a decision granting or denying a waiver or variance in a contested case proceeding shall be in accordance with 701—Chapter 7 governing hearings and appeals from decisions in contested cases. These appeals shall be taken within 30 days of the issuance of the ruling granting or denying the waiver or variance request, unless a different time is provided by rule or statute, such as provided in the area of license revocation (see 701—7.55(17A)).

The provisions of Iowa Code sections 17A.10 to 17A.18A and the department rules 701—Chapter 7 regarding contested case proceedings shall apply to any petition for waiver or variance of a rule or provisions in a rule filed within a contested case proceeding. A petition for waiver or variance of a rule provision in a rule outside of a contested case proceeding will not be considered under the statutes or the department's rules relating to contested case proceedings. Instead, the director's decision on the petition for waiver or variance is considered to be "other agency action."

This rule is intended to implement 2000 Iowa Acts, House File 2206.

DIVISION IV
PETITION FOR RULE MAKING

701—7.61(17A) Petition for rule making.

7.61(1) *Form of petition.* Any person or agency may file a petition for rule making at the Office of the Director, Department of Revenue, Hoover State Office Building, Fourth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319. A petition is deemed filed when it is received by the director. The department will provide the petitioner with a file-stamped copy of the petition if the petitioner provides the department an extra copy for this purpose. The petition must be typewritten or legibly handwritten in ink and must substantially conform to the following form:

DEPARTMENT OF REVENUE

Petition by (Name of Petitioner) for the (adoption, amendment, or repeal) of rules relating to (state subject matter).	}	PETITION FOR RULE MAKING

The petition must provide the following information:

a. A statement of the specific rule-making action sought by the petitioner including the text or a summary of the contents of the proposed rule or amendment to a rule and, if it is a petition to amend or repeal a rule, a citation and the relevant language to the particular portion or portions of the rule proposed to be amended or repealed.

b. A citation to any law deemed relevant to the department's authority to take the action urged or to the desirability of that action.

c. A brief summary of petitioner's arguments in support of the action urged in the petition.

d. A brief summary of any data supporting the action urged in the petition.

e. The names and addresses of other persons, or a description of any class of persons, known by the petitioner to be affected by or interested in the proposed action which is the subject of the petition.

f. Any request by petitioner for a meeting.

g. Any other matters deemed relevant that are not covered by the above requirements.

7.61(2) *Form signed and dated.* The petition must be signed and dated by the petitioner or the petitioner's representative. It must also include the name, mailing address, telephone number and, if requested, the E-mail address of the petitioner and petitioner's representative, and a statement indicating the person to whom communications concerning the petition should be directed.

7.61(3) *Denial by department.* The department may deny a petition because it does not substantially conform to the required form or because all the required information has not been provided.

7.61(4) *Briefs.* The petitioner may attach a brief to the petition in support of the action urged in the petition. The department may request a brief from the petitioner or from any other person concerning the substance of the petition.

7.61(5) *Status of petition.* Inquiries concerning the status of a petition for rule making may be made to the Office of the Director, Department of Revenue, Hoover State Office Building, Fourth Floor, 1305 East Walnut Street, Des Moines, Iowa 50319.

7.61(6) *Informal meeting.* If requested by petitioner in the petition, the department may schedule an informal meeting between the petitioner and the department, or a member of the staff of the department, to discuss the petition. The department may request that the petitioner submit additional information or argument concerning the petition. The department may also solicit comments from any person on the substance of the petition. Also, comments on the substance of the petition may be submitted to the department by any person.

7.61(7) *Action required.* Within 60 days after the filing of the petition, or within an extended period as agreed to by the petitioner, the department must, in writing, either: (a) deny the petition and notify petitioner of its action and the specific grounds for the denial; or (b) grant the petition and notify petitioner that it has instituted rule-making proceedings on the subject of the petition. Petitioner shall be deemed

notified of the denial of the petition or granting of the petition on the date that the department mails or delivers the required notification to petitioner.

7.61(8) *New petition.* Denial of a petition because it does not substantially conform to the required form does not preclude the filing of a new petition on the same subject when the new petition contains the required information that was the basis for the original denial.

This rule is intended to implement Iowa Code chapter 17A.

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CHAPTER 8
SUBSTANTIVE AND INTERPRETIVE RULES

[Prior to 9/24/86 see Industrial Commissioner[500]]
[Prior to 1/29/97 see Industrial Services Division[343]]
[Prior to 7/29/98 see Industrial Services Division[873]Ch 8]

876—8.1(85) Transportation expense. Transportation expense as provided in Iowa Code sections 85.27 and 85.39 shall include but not be limited to the following:

1. The cost of public transportation if tendered by the employer or insurance carrier.
2. All mileage incident to the use of a private auto. The per-mile rate for use of a private auto from August 1, 2005, through June 30, 2006, shall be 40.5 cents. For annual periods beginning July 1, 2006, and thereafter, the per-mile rate shall be the rate allowed by the Internal Revenue Service for the business standard mileage rate in effect on July 1 of each year.
3. Meals and lodging if reasonably incident to the examination.
4. Taxi fares or other forms of local transportation if incident to the use of public transportation.
5. Ambulance service or other special means of transportation if deemed necessary by competent medical evidence or by agreement of the parties.

Transportation expense in the form of reimbursement for mileage which is incurred in the course of treatment or an examination, except under Iowa Code section 85.39, shall be payable at such time as 50 miles or more have accumulated or upon completion of medical care, whichever occurs first. Reimbursement for mileage incurred under Iowa Code section 85.39 shall be paid within a reasonable time after the examination.

The workers' compensation commissioner or a deputy commissioner may order transportation expense to be paid in advance of an examination or treatment. The parties may agree to the advance payment of transportation expense.

This rule is intended to implement Iowa Code sections 85.27 and 85.39.

876—8.2(85) Overtime. The word "overtime" as used in Iowa Code section 85.61 means amounts due in excess of the straight time rate for overtime hours worked. Such excess amounts shall not be considered in determining gross weekly wages within Iowa Code section 85.36. Overtime hours at the straight time rate are included in determining gross weekly earnings.

This rule is intended to implement Iowa Code sections 85.36 and 85.61.

876—8.3 Rescinded, effective July 1, 1982.

876—8.4(85) Salary in lieu of compensation. The excess payment made by an employer in lieu of compensation which exceeds the applicable weekly compensation rate shall not be construed as advance payment with respect to either future temporary disability, healing period, permanent partial disability, permanent total disability or death.

This rule is intended to implement Iowa Code sections 85.31, 85.34, 85.36, 85.37 and 85.61.

876—8.5(85) Appliances. Appliances are defined as hearing aids, corrective lenses, orthodontic devices, dentures, orthopedic braces, or any other artificial device used to provide function or for therapeutic purposes.

Appliances which are for the correction of a condition resulting from an injury or appliances which are damaged or made unusable as a result of an injury or avoidance of an injury are compensable under Iowa Code section 85.27.

876—8.6(85,85A) Calendar days—decimal equivalent. Weekly compensation benefits payable under Iowa Code chapters 85 and 85A are based upon a seven-day calendar week. Each day of weekly compensation benefits due may be paid by multiplying the employee's weekly compensation benefit rate by the decimal equivalents of the number of days as follows:

1 day	= .143	×	weekly rate
2 days	= .286	×	weekly rate
3 days	= .429	×	weekly rate
4 days	= .571	×	weekly rate
5 days	= .714	×	weekly rate
6 days	= .857	×	weekly rate

This rule is intended to implement Iowa Code sections 85.31, 85.33 and 85.34.

876—8.7(86) Short paper. All filings before the workers' compensation commissioner shall be on white paper measuring 8½ inches by 11 inches.

This rule is intended to implement Iowa Code section 86.18.

876—8.8(85,17A) Payroll tax tables. Tables for determining payroll taxes to be used for the period July 1, 2009, through June 30, 2010, are the tables in effect on July 1, 2009, for computation of:

1. Federal income tax withholding according to the percentage method of withholding for weekly payroll period. (Internal Revenue Service, New Wage Withholding and Advance Earned Income Credit Payment Tables, Publication 15-T [Rev. March 2009].)
2. Iowa Withholding Tax Guide. (Iowa Department of Revenue Iowa Withholding Tax Rate Tables [Effective April 1, 2006].)
3. Social Security and Medicare withholding (FICA) at the rate of 7.65 percent. (Internal Revenue Service, Circular E, Employer's Tax Guide, Publication 15 [2009].)

This rule is intended to implement Iowa Code section 85.61(6).
[**ARC 7947B**, IAB 7/15/09, effective 7/1/09]

876—8.9(85,86) Exchange of records. Whether or not a contested case has been commenced, upon the written request of an employee or the representative of an employee who has alleged an injury arising out of and in the course of employment, an employer or insurance carrier shall provide the claimant a copy of all records and reports in its possession generated by a medical provider.

Whether or not a contested case has been commenced, upon the written request of the employer or insurance carrier against which an employee has alleged an injury arising out of and in the course of employment, the employee shall provide the employer or insurance carrier with a patient's waiver. See rules 876—3.1(17A) and 876—4.6(85,86,17A) for the waiver form used in contested cases. Claimant shall cooperate with the employer and insurance carrier to provide patients' waivers in other forms and to update patients' waivers where requested by a medical practitioner or institution.

A medical provider or its agent shall furnish an employer or insurance carrier copies of the initial as well as final clinical assessment without cost when the assessments are requested as supporting documentation to determine liability or for payment of a medical provider's bill for medical services. When requested, a medical provider or its agent shall furnish a legible duplicate of additional records or reports. Except as otherwise provided in this rule, the amount to be paid for furnishing duplicates of records or reports shall be the actual expense to prepare duplicates not to exceed: $20 for 1 to 20 pages; $20 plus $1 per page for 21 to 30 pages; $30 plus $.50 per page for 31 to 100 pages; $65 plus $.25 per page for 101 to 200 pages; $90 plus $.10 per page for more than 200 pages, and the actual expense of postage. No other expenses shall be allowed.

EXAMPLE 1. For 7 pages of records the amount to be paid for furnishing duplicates shall not exceed $20.

EXAMPLE 2. For 28 pages of records the amount to be paid for furnishing duplicates shall not exceed $28 ($20 plus (8 times $1)).

EXAMPLE 3. For 41 pages of records the amount to be paid for furnishing duplicates shall not exceed $35.50 ($30 plus (11 times $.50)).

EXAMPLE 4. For 127 pages of records the amount to be paid for furnishing duplicates shall not exceed $71.75 ($65 plus (27 times $.25)).

EXAMPLE 5. For 210 pages of records the amount to be paid for furnishing duplicates shall not exceed $91 ($90 plus (10 times $.10)).

This rule is intended to implement Iowa Code sections 85.27, 85.31, 85.33 to 85.37, 85.39, 85.61, 86.8, 86.10, 86.18 and 86.39.

876—8.10(85B) Apportionment of age-related loss for occupational hearing loss claims.

8.10(1) *Effective date.* This rule is effective for claims for occupational hearing loss filed on or after July 1, 1998.

8.10(2) *Purpose.* The purposes of this rule are to adopt tables and the method for calculating age-related hearing loss and to adopt a worksheet for apportionment of age-related hearing loss for occupational hearing loss claims.

8.10(3) *Table.* In 1972 the National Institute for Occupational Safety and Health (NIOSH) published the Criteria for a Recommended Standard: Occupational Exposure to Noise (NIOSH Publication No.73-11001). Table B-1, page I-16, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Males and Table B-2, page I-17, provides the Age Corrections Values to be Used for Age Correction of Initial Baseline Audiograms for Females. These NIOSH tables are used to calculate the correction value for age for males and females for 500, 1000, 2000 and 3000 hertz.

For example, the age correction for a male 21 years of age is 10 decibels at 500 hertz, 5 decibels at 1000 hertz, 3 decibels at 2000 hertz and 4 decibels at 3000 hertz. The correction for age is 5.50 decibels (the sum of 10+5+3+4 divided by 4).

The following table is to be used to determine an employee's age-related change in hearing level during the period of employment. To determine the age-related change in hearing level in decibels during the period of employment, subtract the value shown in the table for the employee's age at the beginning of employment from the value shown in the table for the employee's age on the date of injury.

NOTE: This table should not be used to compute standard threshold shift as required by rules of the Occupational Safety and Health Administration or Iowa occupational safety and health administration.

Age in Years	Correction in dB	
	Males	Females
20 or younger	5.50	7.25
21	5.50	7.75
22	5.50	7.75
23	5.50	8.00
24	5.75	8.00
25	6.00	8.25
26	6.25	8.50
27	6.50	8.75
28	6.75	8.75
29	6.75	8.75
30	6.75	9.00
31	7.25	9.25
32	7.50	9.50
33	7.50	9.75
34	7.75	9.75
35	8.00	10.00
36	8.25	10.25
37	8.75	10.25
38	8.75	10.50

Age in Years	Correction in dB	
	Males	Females
39	9.00	11.00
40	9.00	11.00
41	9.25	11.25
42	10.00	11.50
43	10.25	11.75
44	10.25	12.00
45	10.50	12.25
46	10.75	12.50
47	11.00	12.50
48	11.50	13.00
49	12.00	13.25
50	12.25	13.50
51	12.25	13.75
52	12.75	13.75
53	13.25	14.25
54	13.50	14.50
55	14.00	15.00
56	14.25	15.00
57	14.50	15.25
58	15.25	15.75
59	15.50	16.00
60 or older	16.00	16.25

8.10(4) *Apportionment.* The apportionment of age-related hearing loss shall be made by reducing the total binaural percentage hearing loss as calculated pursuant to Iowa Code section 85B.9(3) by the same percentage as the decibels of age-related change in hearing level occurring during the period of employment bears to the total decibel hearing level in each ear.

Age-related hearing loss is apportioned using the results of the audiogram determined to be the proper audiogram for measurement of the employee's hearing loss on the date of injury by using the following steps:

1. Separately for each ear, compute the average of the employee's decibel hearing levels at 500, 1000, 2000, and 3000 hertz for that ear.
2. Separately for each ear, compute the percentage loss for each ear.
3. Compute the employee's age-related change in hearing level in decibels during the period of employment using the table in subrule 8.10(3).
4. Separately for each ear, divide the result of step 3 by the result of step 1 to compute the age-correction factor for that ear.
5. Separately for each ear, multiply the total percentage hearing loss in that ear calculated pursuant to Iowa Code section 85B.9 by the age-correction factor for that ear.
6. Separately for each ear, subtract the result obtained in step 5 from the total percentage hearing loss in that ear to obtain the age-corrected hearing loss for that ear.
7. Multiply the age-corrected hearing loss in the better ear as calculated in step 6 by 5 and add the percentage hearing loss in the worse ear.
8. Divide the result obtained in step 7 by 6 to obtain the age-corrected binaural percentage hearing loss.

8.10(5) *Worksheet.* The following worksheet is used to calculate the percentage of age-corrected binaural hearing loss.

APPORTIONMENT OF PERCENT HEARING LOSS FOR AGE

	Left Ear Hearing Level	Frequency in Hertz	Right Ear Hearing Level
1.	_____	500	_____
2.	_____	1000	_____
3.	_____	2000	_____
4.	_____	3000	_____
5.	_____	total of lines 1 through 4	_____
	divide by 4	(divide the "total" by 4)	divide by 4
6.	_____	equals average equals	_____
	minus 25	subtract "low fence"	minus 25
7.	_____	equals "Excess"	_____
	multiply by 1.5	multiply % factor	multiply by 1.5
8.	_____	equals % loss each ear	_____
	(% loss left ear)		(% loss right ear)
9.	Age on date of injury	_____	
10.	Age at beginning of employment	_____	
11.		____ correction for age on date of injury in dB from table	
		minus	
12.		____ correction for age at beginning of employment in dB from table	
		equals	
13.		____ age-related change in hearing level during employment in dB	

LEFT EAR		RIGHT EAR
	Divide age-related change in hearing level from line 13 by average hearing level from line 6	
	To obtain	
14. _____	age correction factor	_____
	multiply % loss from line 8 by age-correction factor from line 14	
	To obtain	
15. _____	deduction for age-correction	_____
	subtract line 15 from line 8	
	To obtain	
16. _____	age-corrected percent hearing loss	_____

BINAURAL PERCENTAGE LOSS

17. _____	% loss better ear (smaller amount) from line 16, multiplied by 5
	plus

18. _____ % loss worse ear (larger amount) from line 16

19. _____ equals

divided by 6

equals

20. _____ % age-corrected binaural hearing loss

This rule is intended to implement Iowa Code sections 85B.9A and 86.8.

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◊ Two or more ARCs

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